U.S. Department of Labor

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Case Nos: 1999-LHC-02277
2001-LHC-00432

OWCP Nos.: 02-105364
02-225596

In the Matter of

JUAN ALMANZAR,
Claimant

v.

BRADY MARINE REPAIR COMPANY, INCORPORATED,
Employer,

CIGNA,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Jorden N. Pedersen, Esquire
For the claimant

Kenneth L. Flicker, Esquire
Robert N. Dengler, Esquire
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from two claims for workers' compensation benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901 *et seq.* (hereinafter "the LHWCA" or "the Act"). On October 22, 1991, Mr. Almanzar filed a claim for compensation under the Act against Brady Marine Repair Company, Incorporated (hereinafter "Brady Marine") based on injuries Mr. Almanzar allegedly sustained on May 14, 1991in a work-related accident. (CX 1). The accident occurred at Brady Marine's Trumbull Street facility in Elizabeth, New Jersey when Mr. Almanzar was struck by a company truck while welding. (CX 1). In his October 1991 complaint, Mr. Almanzar alleged injury to his head, a fractured jaw, loss of two teeth, loss of vision in his left-eye, permanent injury to his back and shoulder, as well as neurological, neuropsychiatric and opthalmological complaints. Mr. Almanzar received temporary total disability benefits from Brady Marine from May 15, 1991 through April 26, 1996, at which time benefits were terminated. (CX 13). He received $464.96 per week for 258.4 weeks for a total of $120, 164.09 in temporary total disability benefits.

On December 7, 1994, Mr. Almanzar filed a second claim for benefits under the Act, alleging he suffers from an occupational pulmonary condition caused by his exposure to dust, fumes, asbestos, and other deleterious fumes and substances while employed at Brady Marine. (CX 18). By Order dated November 20, 2000, I consolidated Mr. Almanzar's two claims and scheduled the case for a calendar call on Monday, December 11, 2000 in New York, New York.

Mr. Almanzar has also filed several state workers' compensation claims. The Claimant filed a compensation claim with the State of New Jersey on August 27, 1986, alleging a respiratory injury caused by exposure to asbestos, dust, lead paints, and sandpaper dust. (EX 9). The claim was dismissed for failure to prosecute on October 27, 1988. Mr. Almanzar file a second claim for compensation with the State of New Jersey on January 17, 1986, based on injuries he sustained to his lower back and buttocks during a fall on a boat. Union Dry Dock settled the claim with Mr. Almanzar on May 17, 1990. Mr. Almanzar filed a third state workers' compensation claim on January 27, 1989, again alleging occupational pulmonary injury caused by exposure to fumes, dust, chemicals, paints, sandblasting, welding dust, and other deleterious fumes and substances. Union Dry Dock settled this claim with Mr. Almanzar on May 17, 1990.

Following proper notice to all parties, a formal hearing was held in full accordance with the Administrative Procedure Act, 5 U.S.C. § 500, *et seq.*, on December 12, 2000 in New York. Claimant's Exhibits 1-24 and Employer's Exhibits 1-16 were admitted into evidence at the hearing pursuant to 20 C.F.R. § 702.338. The Director did not submit any exhibits at the hearing. The parties were afforded an opportunity to present testimonial evidence and either closing arguments or post-

hearing briefs. A post-hearing brief on behalf of the Employer was received on March 12, 2001. A post-hearing brief on behalf of the Claimant was received on March 15, 2001.

Regarding Mr. Almanzar's traumatic injury claim, the parties have stipulated that Mr. Almanzar was involved in a work-related accident on May 14, 1991; that the Claimant and the Employer were in an employer/employee relationship at the time of the accident; that the injuries Mr. Almanzar sustained during the accident arose out of, and in the course of, Mr. Almanzar's employment with Brady Marine; that the claim was timely filed, noticed, and controverted; and that Mr. Almanzar received temporary total disability payments from Brady Marine in the amount of $464.98 for 258.42 weeks from May 15, 1991 through April 26, 1996 which totaled $120, 164.09; and, that the Claimant's average weekly wage at the time of the accident was $697.47. However, the following issues are still in dispute with respect to Mr. Almanzar's traumatic injury claim:

1) whether the claim is covered under the Act (jurisdiction), specifically whether Mr. Almanzar was injured at a situs covered by the Act;

2) the nature and extent of any permanent disability related to the May 14, 1991 accident;

3) whether the Claimant is entitled to permanent total disability, or in the alternative, unscheduled permanent partial disability;

4) the date of maximum medical improvement; and

5) whether the Employer is entitled to relief under Section 8(f) of the Act.

(CX 1. Claimant's Post-Hearing Brief, pp. 2-3; Employer's Post-Hearing Brief, p. 5, Tr. 6-10).

The parties have stipulated that with respect to Mr. Almanzar's alleged pulmonary injury, the claim is covered by the Act, the Claimant and the Employer were in an employer/employee relationship, the claim was timely noticed, filed and controverted, and that maximum medical improvement occurred in either 1991 or 1994. The parties have also stipulated that Dr. Bernard Eisenstein's 1988 medical report was in existence on May 14, 1991. (Tr. 8). However, the following issues related to the Claimant's alleged pulmonary injury remain for adjudication:

1) whether Mr. Almanzar sustained a pulmonary injury arising out of and in the course of his employment with Brady Marine;

2) the nature and extent of any disability resulting from that injury;

3) whether the named employer is the last responsible employer;

4) whether the Claimant is entitled to permanent total disability, or in the alternative, permanent partial disability; and

5) the date of maximum medical improvement.

(CX 17. Claimant's Post-Hearing Brief, p. 3; Employer's Post-Hearing Brief, p. 5, Tr. 6-10).

FINDINGS OF FACT

Juan Almanzar was born in the Dominican Republic on July 7, 1945. (Tr. 14). He has an eighth grade education. Mr. Almanzar came to live in the United States in 1970. (Tr. 16). He was employed as a welder for Union Dry Dock in Hoboken, New Jersey from 1970 to 1987. He describes his job as a welder as "heavy work" which involved soldering and welding on barges and ships, climbing ladders, and working on scaffolding. (Tr. 16-17). From the time he left his employment with Union Dry Dock in 1987 until some time during 1989, Mr. Almanzar was unemployed. (Tr. 18). The Claimant then began working as a welder for Bethlehem Steel. Some time thereafter, Mr. Almanzar became an employee of Brady Marine Repair Company, Incorporated. Brady Marine was located at 399-419 Trumbull Street in Elizabeth, New Jersey (hereinafter "the Trumbull Street Facility") during the time Mr. Almanzar worked for the company.

Brady Marine is a ship repair company. (Tr. 65). Its customers are various ship owning companies who come to a port with a ship that needs to be repaired. The ship owning companies notify Brady Marine of a job order and Brady Marine carries out the repair requests. (Tr. 67). In 1991, approximately 75% of Brady Marine's work was related to the Port Elizabeth Facility and about 25% of its work was related to pier facilities around the world. (Tr. 68). Brady Marine's Trumbull Street Facility was a one-story structure with approximately 21,000 to 22,000 square feet. (Tr. 69). The Trumbull Street Facility housed a machine shop, a burning and fabrication shop, and pump and valve repair tables. The company made repairs to ships from the Trumbull Street Facility. Daniel Muirhead, the current vice-president of Brady Marine, testified that Brady Marine's repair shop is an integral part of his business of performing ship repairs; however, he also testified that the proximity of his business to the port plays no role in its location. (Tr. 90). Mr. Muirhead stated there are times when Brady Marine employees go to a ship docked in Port Elizabeth, pick up a part that needs to be repaired, bring the part to the shop for repairs, and return the part to the ship upon completing the repairs. (Tr. 89). However, Mr. Muirhead stated there is no business reason requiring Brady to be on the pier. (Tr. 88). Mr. Almanzar testified that 90% of his repair work for Brady Marine was performed on ships. (Tr. 35).

The parties disagree as to the distance between the Trumbull Street Facility and the nearest navigable waterway in Port Elizabeth. Mr. Muirhead stated the Trumbull Street Facility was "a little bit over four miles" by car from Port Elizabeth. (Tr. 74). Mr. Muirhead also testified the distance between the Trumbull Street Facility and Newark Bay is less than one mile by air. (Tr. 95). The

Claimant alleges the driving distance between the Trumbull Street Facility and Port Elizabeth is one and three-fourths miles. (Tr. 20). Mr. Muirhead testified he drove the route and his vehicle's odometer indicated the distance between the Trumbull Street Facility and the Sea-Land security guard shack is 4.2 miles. (Tr. 100). Mr. Almanzar testified he measured the distance between the Trumbull Street Facility and Port Elizabeth by watching the odometer of a Brady Marine vehicle in which he rode to the port. (Tr. 20).

The individual who owned Brady Marine at the time the Complainant was injured is now deceased. (Tr. 84). Neither the Claimant nor the Employer knows what motivated the previous owner of Brady Marine to choose the Trumbull Street location. (Tr. 79). Mr. Muirhead was an employee of the previous owner of Brady Marine. He stated the previous owner indicated to him that she was concerned about the increased cost that would be associated with moving the company from the Trumbull Street Facility to the pier. (Tr. 79). Apparently, Brady Marine had to move from the Trumbull Street Facility because the construction of the New Jersey turnpike would cut the facility in half. (Tr. 85). Mr. Muirhead explained that, in addition to the cost factor, Brady Marine prefers to be located off the pier because of certain restrictions the Port Authority places on tenants of the pier. He also stated it is his understanding that in 1991, the rent on the pier was more expensive than the rental prices off the pier. (Tr. 84).

The companies occupying facilities near the Trumbull Street Facility included a tea factory across the street (Tr. 74), a burning and welding supply company next door (Tr. 75), a retail bank near the facility, the Singer building which housed a number of factories (Tr. 77), a clothing manufacturer (Tr. 76), a corner bar with a residential dwelling above it (Tr. 77), a commercial egg factory west of the shop (Tr. 78), and a Brown Derby bar less than one mile away in a residential area (Tr. 79). Mr. Muirhead stated that, with the exception of some residential areas on Dowd Street, the areas north and east of the Trumbull Street Facility are "all commercial." (Tr. 92). There are businesses between Trumbull Street and Port Elizabeth that do business at the port. (Tr. 93). There are also businesses that have nothing to do with the port located on the way from the Trumbull Street Facility to Port Elizabeth. A number of trucking companies which transport containers to and from the port are located between the Trumbull Street Facility and the entrance to the Sea-Land terminal at Port Elizabeth. (Tr. 96).

On May 14, 1991, Mr. Almanzar was working at the Trumbull Street Facility when he was struck by a truck while welding. (Tr. 23). The truck was returning from Port Elizabeth with some materials for the Claimant to weld. Mr. Almanzar testified that had the accident not occurred, he would have welded the materials and gone to a ship docked in the port to install them. (Tr. 23).

Medical Evidence

Medical records from Elizabeth General Medical Center indicate Mr. Almanzar was hospitalized from May 14, 1991 through May 21, 1991 due to the injuries he sustained in the accident at the Trumbull Street facility on May 14, 1991. (CX 2). Dr. Robert described Mr. Almanzar's

injuries as "severe lacerations of the face, forearm and left eye area, as well as multiple traumas to his chest, neck, abdomen, and back." During his hospital stay, Mr.

Almanzar was seen by several consulting physicians. Dr. M. Bercik evaluated Mr. Almanzar's condition from an orthopedic standpoint and concluded the Claimant sustained cervical, lumbosacral, and right shoulder sprains during the accident. The physician recommended the Claimant receive bed rest and analgesics. Dr. Bercik concluded traction treatment and physical therapy would likely be prescribed once Mr. Almanzar's non-orthopedic problems were resolved.

Dr. J. Calderone treated Mr. Almanzar for an eye injury he sustained during the accident. (CX 2). Dr. Calderone diagnosed the Claimant with an eyelid laceration, a periorbital contusion and secondary dry eye. The physician noted he reviewed a computed tomography scan of the Claimant's eye which showed no orbital or ocular pathology. Dr. Calderone expected Mr. Almanzar's vision to be restored when the swelling in the upper eyelid resolved and the eyelid returned to its normal function. The records from Elizabeth General Medical Center also indicate Dr. Frederick Meiselman treated Mr. Almanzar for a fractured left mandible sustained during the accident.

According to Dr. Donald Whitaker, a series of x-rays were administered during a May 14, 1991 examination of Mr. Almanzar which revealed a left mandibular angle fracture, no evidence of acute cervical spine pathology, no evidence of a skull fracture, mild degenerative osteoarthritic changes in the spine, and no evidence of active pulmonary disease. A May 19, 1991 chest x-ray was also normal, according to Dr. Khee Tiang Oen. Dr. Robert Silby interpreted a May 14, 1991 computed tomography scan of the Claimant's abdomen as revealing a small, right renal cyst, but thought the scan was otherwise normal. The physician also administered a computed tomography scan of the Claimant's head and orbits which was normal but revealed evidence of soft tissue swelling in the soft tissues of the left frontal region. On May 17, 1991, Dr. Meiselman performed surgery on Mr. Almanzar's jaw to repair the fractured mandible. The Claimant underwent an arterial blood gas study on May 19, 1991.

On June 10, 1991, Dr. Meiselman submitted a report summarizing his treatment of Mr. Almanzar during the Claimant's May 1991 hospitalization. (CX 3). Dr. Meiselman is board-certified in oral and maxillofacial surgery. The physician stated the Claimant sustained a "displaced fracture of the left body of the mandible." Dr. Meiselman repaired the fractured jaw on May 17, 1991. The physician noted Mr. Almanzar's jaw injury was solely the result of the May 14, 1991 accident at the Trumbull Street facility. Dr. Meiselman opined Mr. Almanzar's prognosis is "very good" and that the Claimant should fully regain mandibular function. The physician treated the Claimant until August 16, 1991 when he discharged the Claimant from active treatment with a radiographically healing fracture of the left mandible.

Dr. Andrew Hutter, an orthopaedic surgeon, examined Mr. Almanzar on June 11, 1991. (CX 7). Dr. Hutter noted Mr. Almanzar had received no orthopaedic treatment since his discharge from the hospital less than one month prior. At that time, the Claimant was experiencing neck, right shoulder, and lower back pain. Dr. Hutter's examination included x-rays of the cervical spine, lumbar spine, and right shoulder. According to Dr. Hutter, the x-rays of the cervical spine and right shoulder were essentially normal. X-rays of the lumbar spine showed mild degenerative changes. Dr. Hutter diagnosed Mr. Almanzar with a cervical strain, right shoulder contusion, capsular strain, and a lumbar strain. The physician recommended "an aggressive course of physical therapy with pain control modalities, range of motion, and flexibility." Dr. Hutter prescribed anti-inflammatory medication to help relieve the pain.

Dr. Frederick Lepore evaluated Mr. Almanzar for his vision problems on July 11, 1991. (CX 5). Mr. Almanzar was continuing to have pain in his left eye. Dr. Lepore diagnosed Mr. Almanzar with marked impairment of visual function in both eyes. The physician stated the following factors contributed to the Claimant's visual impairment: bilateral diabetic retinopathy, refractive error, and possible bilateral traumatic optic neuropathy. Dr. Lepore also noted gun barrel or tubular vision field and sensory loss on left side of face complicated Mr. Almanzar's condition. Dr. Lepore thought it would be "extremely problematic to unequivocally demonstrate a traumatic optic neuropathy in a patient with retinal disease and functional visual symptoms." The physician recommended a visual evoked response and MRI of the orbits and stated the Claimant should be followed by an opthalmologist for his diabetic retinal disease and for routine refraction. Dr. Lepore found it extremely difficult to provide a visual prognosis for Mr. Almanzar, given the fact that the physician thought the Claimant suffered from two to three visual problems and has a background of post-concussion syndrome. The physician recommended Mr. Almanzar refrain from driving because of his "marked constriction of peripheral vision and his need for visual refraction." At the suggestion of Dr. Lepore, the Claimant underwent an MRI of the eyes, orbits, and brain on August 26, 1991. (CX 6). Dr. Andrew Carothers interpreted the MRI as normal.

Dr. Hutter treated Mr. Almanzar's orthopedic condition again on August 27, 1991. (CX 7). The physician's notes indicate Mr. Almanzar had a good range of motion, but was still experiencing "tenderness in the AC joint." The physician noted no change in the lumbar region. Dr. Hutter recommended the Claimant continue physical therapy for one additional month and then return for another evaluation. Dr. Hutter expected that in one month, Mr. Almanzar "most likely" would have reached his maximum orthopaedic benefit. The physician stated the Claimant's "ability to return to work was significantly hampered by his visual problems." Dr. Hutter noted Mr. Almanzar's headaches may be related to a post-concussive syndrome and referred the Claimant to a neurologist.

Dr. Stuart Mendelson treated Mr. Almanzar from October 1991 through February 1992. (EX 7). Dr. Mendelson is board-certified in psychiatry and neurology. The Claimant was first evaluated by Dr. Mendelson on September 23, 1991. (CX 4). The Claimant was complaining of a constant left-sided headache. The physician noted Mr. Almanzar described the pain in his head as sharp, throbbing, and intense. The Claimant stated the pain prevented him from sleeping more than two to three hours

per night. Mr. Almanzar was taking Motrin and Tylenol for his pain but stated neither medication provided much pain relief. Dr. Mendelson noted the Claimant suffers from insulin dependent diabetes mellitus. Dr. Mendelson concluded the Claimant's history and physical examination suggest a post-traumatic headache syndrome with substantial functional overlay.

Dr. Mendelson treated Mr. Almanzar on a follow-up basis on October 24, 1991. (EX 7). Mr. Almanzar complained of the same symptoms he reported during the prior visit: headaches, sleeplessness, forgetfulness, loss of vision and facial numbness. Dr. Mendelson stated Mr. Almanzar's neurologic examination was normal except that the Claimant reported an absent pinprick sensation over the entire left side of his body and face. The physician commented the Claimant's diagnostic studies were unremarkable and provided no explanation for his headaches and visual and sensory complaints. It was not clear to Dr. Mendelson whether any organic basis for the Claimant's complaints existed.

Mr. Almanzar returned to Dr. Mendelson's office for a follow-up visit on November 5, 1991. (CX 4). Dr. Mendelson noted an October 22, 1991 electrocardiogram showed a normal sinus rhythm, but Q waves were present in the inferior leads, suggesting a possible, old inferior wall myocardial infarction. However, the physician noted Mr. Almanzar did not have a clinical history of chest pain or myocardial infarction at that time. Dr. Mendelson again noted Mr. Almanzar had multiple complaints for which Dr. Mendelson could find no organic basis. Because of Mr. Almanzar's abnormal electrocardiogram and complaints of dysuria, Dr. Mendelson recommended the Claimant see an internist and then follow up with Dr. Mendelson
in three weeks.

During a November 26, 1991 visit, Dr. Mendelson again explained to Mr. Almanzar that he found no organic basis for Mr. Almanzar's symptoms and suggested there might be an emotional component to the Claimant's complaints. (EX 7). The physician stated Mr. Almanzar denied such a statement and was convinced all of his symptoms stemmed from the work accident. The physician also stated a psychiatric evaluation may be in order and stated he would determine if such an evaluation was necessary during the next follow-up visit.

On December 17, 1991, Dr. Mendelson noted the Claimant was suffering from the same symptoms: daily headache, insomnia, left facial numbness, and decreased visual acuity in both eyes. (EX 7). The physician reiterated there may be "substantial secondary gain in [Mr. Almanzar's] ongoing symptoms and complaints." Dr. Mendelson was not optimistic about improving the Claimant's condition unless the issue of secondary gain was addressed.

The physician treated Mr. Almanzar again on January 15, 1992. (EX 7). Dr. Mendelson stated the Claimant's complaints are consistently non-physiologic in nature. The physician opined the headaches may be post-traumatic but stated he believes the Claimant has significant secondary gain in continuing to complain of pain and disability. The physician stated the secondary gain included not having to return to work while collecting disability, receiving a cap on his child support payments, and the fact that there was a lawsuit pending. Dr. Mendelson felt a psychiatric evaluation was necessary

because Mr. Almanzar's headaches could be a manifestation of anxiety with respect to returning to work.

Mr. Almanzar returned to Dr. Mendelson on January 20, 1992. (CX 4). The Claimant had seen no improvement in the frequency or the intensity of his headaches and was still complaining of left facial numbness. Dr. Mendelson noted Mr. Almanzar's complaints are consistently non-physiologic in nature." The physician stated the Claimant's headaches may be post-traumatic, but thought the Claimant had "significant secondary gain in continuing to complain of pain and disability." Dr. Mendelson noted Mr. Almanzar would not have to return to work by collecting his disability, was receiving a cap on his child support payments, and had a lawsuit pending. Dr. Mendelson recommended Mr. Almanzar undergo a psychiatric evaluation because the physician thought the Claimant's headaches could be the result of anxiety about returning to work or depression.

Dr. Mendelson also treated the Claimant on February 12, 1992 and July 22, 1992. On February 12, 1992, the Claimant was still complaining of persistent daily headaches. (CX 4). Mr. Almanzar was also complaining of palpitations and thought taking Halcion at bedtime improved his ability to sleep. Dr. Mendelson found the Claimant's neurological examination to be unchanged. He stated Mr. Almanzar had full spontaneous eye movements but refused to look fully in any direction upon command. Dr. Mendelson left open the date of the Claimant's next follow-up visit pending Mr. Almanzar's psychiatric evaluation. During the July 22, 1992 visit, the physician noted the Claimant's physical examination was unchanged from previous examinations. (EX 7). The physician recommended the Claimant be evaluated by the oral surgeon who treated him in the past to determine whether the Claimant's left sided headaches are caused by dental or TMJ disease, given his history of jaw trauma. Dr. Mendelson also stated he agreed with Dr. Moreno's "assessment of the situation," but still questioned secondary gain as a motivating factor because there was still a lawsuit pending. The Claimant returned to Dr. Mendelson's office on December 16, 1992 and stated he felt essentially the same as in the past. During the examination, Mr. Almanzar demonstrated no difficulty in looking fully to the left and right. Dr. Mendelson concluded the Claimant had reached maximum medical benefit from treating with him and found no reason why the Claimant could not return to work.

Dr. Meiselman treated Mr. Almanzar again on August 18, 1992. (CX 3). During the August 18, 1992 examination, Dr. Meiselman noted "normal intraoral findings for a fully edentulous mandible." The physician stated a panographic x-ray revealed complete osseous repair at the fracture site. Stethoscopic auscultation of the temporomandibular joints revealed no clicking or crepitus and the mandible demonstrated full ranges of motion. At the time of Dr. Meiselman's examination, Mr. Almanzar complained of persistent pain of the left forehead. Dr. Meiselman stated he could not address the source of the persistent forehead pain, but stated the pain may be the result of hyperesthesia secondary to the laceration and blunt trauma to the forehead.

Dr. Meiselman treated Mr. Almanzar several weeks prior to March 19, 1993. The Claimant complained that the left mandibular bone plate was interfering with his ability to comfortably wear his lower dentures. Dr. Meiselman clinically confirmed the Claimant's complaint and recommended

removal of the plate. He stated the surgery would require one day of hospitalization, post-operative medications for pain, antibiotics, and removal of skin sutures one week after the surgery. The physician noted construction of the lower dentures could begin within

weeks of the plate removal. On April 6, 1993, Mr. Almanzar underwent a surgical procedure to have his left mandibular bone plate removed. (CX 9). Dr. Meiselman performed the surgery.

Dr. Meiselman treated Mr. Almanzar on April 27, 1993. At that time, the Claimant was complaining that his jaw deviated to the right and was catching his lower lip between his teeth. Dr. Meiselman found no deviation of the mandible, but noted the occlusion of the Claimant's dentures was set so that there was a crossbite on the right side and malocclusion on the left side. The physician recommended either occlussal adjustment of the dentures or a remount placing teeth in a normal occlusion.

Dr. Lepore treated Mr. Almanzar for visual dysfunction again on March 16, 1993. (CX 5). The physician commented that a brain MRI showed no evidence of lesions of the anterior visual pathways and that the visual evoked response was normal. Mr. Almanzar was complaining of severe left orbital and head pain. Dr. Lepore diagnosed the Claimant with status post head trauma, diabetic retinopathy, refractive error, and functional and visual sensory loss. Dr. Lepore noted Mr. Almanzar's visual status was not as good as it was during his 1991 examination. The physician stated Mr. Almanzar showed signs of conversion symptoms during the examination of his visual system. Dr. Lepore also commented that the Claimant's left facial sensory loss and gun barrel configuration visual fields do not suggest true organic dysfunction of the central nervous system. The physician concluded the restricted nature of the Claimant's visual function would make returning to work or driving medically inadvisable.

Mr. Almanzar received a psychiatric evaluation from Dr. J. G. Moreno on March 13, 1992. (CX 8). Mr. Almanzar was continuing to experience headaches, right shoulder, arm, and lower back pain. The Claimant also stated he was experiencing nightmares that reminded him of the accident at work. Mr. Almanzar reported to Dr. Moreno that he was very sociable before the May 1991 accident, but stated he stays at home "all of the time" because of his fear of falling down and because of his headaches. The Claimant also reported that he becomes irritable, very snappy, and is easily frightened. Dr. Moreno characterized the Claimant's mood during the evaluation as depressed and his affect as sad and withdrawn. The physician diagnosed Mr. Almanzar with an adjustment disorder with mixed emotional features and stated amnestic syndrome and organic mood syndrome needed to be ruled out as possible diagnoses. Dr. Moreno stated the Claimant's mental status was a combination of depression and anxiety which appear to have been triggered by the difficulties the Claimant had experienced since the accident at work.

According to Dr. Moreno, the Claimant's mental status examination revealed the presence of an impairment in short and long term memory, a finding which Dr. Moreno thought was not unusual

after one sustains a traumatic head injury. Dr. Moreno recommended further assessment to clarify the possibility of amnestic syndrome because Mr. Almanzar showed difficulty in abstract thinking and impaired judgment; however, the physician acknowledged such factors may be a product of the Claimant's socio-cultural background. Dr. Moreno thought the Claimant's depressed, labile mood may suggest the possibility of an organic mood syndrome. The physician opined the emotional component of Mr. Almanzar's condition "may contribute to [the Claimant's] distorting his objectivity in terms of appreciating pain as well as other physical complaints." Dr. Moreno noted the Claimant had a cluster of symptoms which appeared to be in excess of his actual medical condition.

Dr. Moreno opined Mr. Almanzar was in need of psychiatric intervention in the form of psychotherapy and psychopharmacotherapy in the form of antidepressants. The physician suggested a course of treatment of no less than six months because antidepressants were involved. Dr. Moreno characterized the Claimant's prognosis as "guarded" and stated the Claimant was slightly to moderately impaired in his ability to comprehend and follow instructions. The physician stated the memory impairment found on the mental status examination had a direct, adverse impact on the Claimant's work function. Dr. Moreno stated the Claimant's ability to perform simple repetitive tasks was slightly to moderately impaired because of the Claimant's cognitive impairment. The physician noted a slight to moderate impairment in the Claimant's ability to maintain a work pace appropriate to a given work load due to the Claimant's symptoms of depression. The physician stated Mr. Almanzar's ability to complete a normal work day or week, performing at a consistent pace without excessive periods of rest was also impaired, primarily because of the chronic pain of which the Claimant complains. Dr. Moreno noted a slight to moderate impairment in Mr. Almanzar's ability to perform complex and varied tasks because of the Claimant's inability to attain established limits, tolerances, or standards within a work situation. The physician stated Mr. Almanzar was moderately impaired in his ability to consistently and effectively influence people; however, the physician stated this impairment may not be crucial because the Claimant did not, to Dr. Moreno's knowledge, act in a supervisory capacity at work. The physician stated the Claimant was slightly impaired in his ability to make generalizations, evaluations or decisions without immediate supervision. The physician found no impairment in the Claimant's ability to carry out responsibility for direction, control and planning within a job because the Claimant never attained any supervisory positions although he maintained his job at a constant level.

Dr. Moreno prepared a July 31, 1992 report on Mr. Almanzar which indicates the Claimant had been continuing his sessions with Dr. Moreno. The physician noted difficulties in dealing with the Claimant's medications and stated he had opted for a "cognitive, here and now approach" to treating Mr. Almanzar. He began asking the Claimant to take his prescribed pain medications before coming to his psychotherapy sessions so that Mr. Almanzar would talk about something else other than his headache. Dr. Moreno also prescribed Prozac for the Claimant. In an August 31, 1992 report, the physician stated the Claimant's headache pain had decreased in severity but was still present. The physician stated the Claimant's mood was much improved. In a September 30, 1992 report, Dr.

Moreno noted noticeable improvement in the Claimant's mood, headaches, and symptoms. In a November 11, 1992 report, Dr. Moreno noted Mr. Almanzar complained of a regression of his condition and was concerned about Dr. Moreno possibly wanting him to return to work. Dr. Moreno felt there may be "secondary gain on the patient's side" and stated he would like to have the Claimant evaluated by a neurologist because he could not believe the Claimant could make such a regression in such a short time.

Dr. Moreno treated the Claimant twice during January 1993. During a January 6, 1993 visit, Dr. Moreno stated the Claimant complained of headaches and that his condition had not improved at all. The physician stated Mr. Almanzar was in a very angry mood, with a labile affect, as well as with an obvious degree of despondency. During a January 19, 1993 visit, Dr. Moreno noted Mr. Almanzar was making a "conscious attempt" to aggravate his symptomology. The physician stated that if the Claimant exhibited some improvement during his next visit, he should be able to return to a work situation on at least a part-time basis.

In a June 21, 1993 report, Dr. Moreno stated he had found it difficult to engage the Claimant in therapy because the Claimant was "extremely fixated on his physical complaints and offered contradictory statements as to the severity of his symptoms...." The physician stated a mental status examination demonstrated the Claimant's ability to remember immediate, recent, and remote events, although the Claimant complained of "forgetting everything." Dr. Moreno found no clear memory impairment, but stated the patient did not answer the questions designed to test memory, as if in a purposeful manner. Dr. Moreno found Mr. Almanzar's status to be similar and unchanged as compared to previous appointments. Dr. Moreno further stated the Claimant's treatment could not be considered short-term in nature because of the difficulties the physician was experiencing with psychiatric intervention.

In an August 3, 1993 report, Dr. Moreno's assessment of the Claimant's psychiatric condition remained unchanged. On November 1, 1993, Mr. Almanzar continued to complain of problems sleeping, severe headaches, and an inability to see with his left eye. Dr. Moreno noted the Claimant's complaints were "in frank contradiction" to his observation of the Claimant. Dr. Moreno opined Mr. Almanzar had reached the maximum benefit from psychiatric treatment. The physician reiterated that he was unable to reconcile Mr. Almanzar's complaints with his own observations of Mr. Almanzar or with the activities and behaviors in which Mr. Almanzar indicated he engaged. The physician suggested that consideration be given to having the Claimant reintegrate himself into the work force in a job appropriate for his capabilities.

Dr. Anthony Panariello, a physician who is board-certified in opthalmology, evaluated the Claimant on May 14, 1993 for complaints of headaches and blurred vision in the left eye. (CX 10). Dr. Panariello determine Mr. Almanzar's visual acuity without glasses was 20/70 in the right eye and 20/400 in the left eye. With refraction, Mr. Almanzar's vision improved to 20/25 in the right eye and 20/70 in the left eye. A fundus evaluation revealed changes of non-proliferative diabetic retinopathy in

both eyes with a suggestion of macular edema in the left eye. Dr. Panierello concluded Mr. Almanzar suffers from post-concussive syndrome and non-proliferative diabetic retinopathy. The physician opined the "main cause" of the Claimant's visual loss is diabetic-retinopathy and advised the Claimant to see a retinal specialist.

On May 17, 1993, Mr. Almanzar was evaluated by Dr. James Feretti, a physician who is board-certified in neurology and psychiatry. (CX 11). Dr. Ferretti is also a board-certified

forensic examiner. Mr. Almanzar complained of headaches, neck pain, back pain, temporomandibular joint pain, and dizziness. The physician noted the Claimant's psychiatric complaints concerned anxiety, depression, and a neuropsychological deficit involving concentration, memory function, and phobia. The Claimant also reported "hearing voices talking to him during diurnal hours as well as nocturnally." The physician noted Mr. Almanzar was laborious and slow in responding to questions about his address, phone number, and children's names. When asked to spell the word "mundo" backwards in Spanish, the Claimant correctly spelled the word, but left off the last letter. Dr. Feretti stated "near misses like this are frequently encountered in individuals engaging in dissimilation or malingering for purposes of secondary gain." Dr. Feretti stated it is not clear whether the Claimant has a cognitive deficit secondary to his head trauma,
or if the Claimant's complaints are "exaggerated and dramatized." The physician recommended a complete neuropsychological battery to "quantify and individuate" the Claimant's alleged deficiency.

Dr. Feretti diagnosed Mr. Almanzar with an adjustment reaction of adult life with features of anxiety, depression and phobia. The physician indicated he based this diagnosis on the assumption that Mr. Almanzar was reasonably truthful and accurate in his narration. He stated if this were not the case, his diagnosis, recommendations, and prognosis could conceivably be altered. Dr. Feretti also diagnosed the Claimant with a possible neuropsychological dysfunction and post-traumatic headaches in partial remission with complaints of dizziness and cervical lumbosacral pain, and insulin dependent diabetes mellitus with diabetic retinopathy. Dr. Feretti commented that "Mr. Almanzar's responses are striking in that they are different from information provided by his attending psychiatrist of several months." The physician noted Dr. Moreno, the patient's attending psychiatrist, seriously considered the possibility of secondary gain, as did other attending physicians. Dr. Feretti stated Mr. Almanzar's complaints of phobia and other aspects of his deportment seemed to support these psychiatrists' conclusions. Dr. Feretti acknowledged there may be some basis for Mr. Almanzar's complaints, but stated malingering must be a "major concern." Dr. Feretti opined the Claimant was nearing the point of maximum medical benefit from outpatient psychiatric treatment. He recommended a tapering off program with reduction and elimination of medication for a period not to exceed ten weeks. The physician noted there appears to be no psychiatric permanency and that secondary gain should be addressed.

Dr. Richard Filippone evaluated Mr. Almanzar on August 8, 1993. (EX 8). After conducting numerous tests on the Claimant, Dr. Filippone stated he could not properly evaluate the Claimant for his

true cognitive abilities because of the claimant's lack of proper motivation to give accurate responses representative of his maximal abilities. The physician stated:

> One might wonder whether or not this is a form of conversion hysteria as indicated in the other medical doctors' reports. This was considered by me as well. The diagnosis that would be given in this case, however, is a Ganser's syndrome (please review enclosed sheet on Ganser's syndrome) which is a rare psychiatric disorder in which a patient mimics a head injured individual with psychotic features. However, Mr. Almanzar has been on anti-psychotic
> medications with no relief in his symptoms. In fact, he still complains of hallucinations. The other possibility, therefore, is the issue of secondary gains and malingering.

In Dr. Filippone's opinion, Mr. Almanzar's performance was not consistent with a head injury in any way due to the severity on some of the cognitive results, inconsistency on others, and the complete lack of correlation between his cognitive skills and capacity to perform activities of daily living. The physician stated he could only conclude Mr. Almanzar is "faking both psychiatric problems, cognitive deficits, and that his motivation is secondary gain, i.e., his civil action and disability claim." Dr. Filippone concluded continued psychiatric treatment was not necessary. The physician acknowledged the Claimant may have suffered headaches following his accident, but stated the degree to which the Claimant still suffers headaches could not be ascertained due to the Claimant's malingering.

Dr. Bernard Eisenstein examined Mr. Almanzar on three occasions.[1] Dr. Eisenstein is board-certified in internal medicine. Dr. Eisenstein examined Mr. Almanzar on August 11, 1994. (CX 18). The physician reviewed Mr. Almanzar's medical history and noted the Claimant is a nonsmoker and worked as a welder at Brady Marine for three years. Scattered areas of expiratory wheezing were noted on physical examination. During his November 13, 2000 deposition, Dr. Eisenstein explained a finding of scattered areas of expiratory wheezing indicates bronchial obstruction. (CX 23). A chest x-ray revealed increased bronchovascular markings. (CX 18). Dr. Eisenstein testified that the exaggerated bronchial markings noted on the chest x-ray are another sign of bronchial disease. (CX 18). Dr. Eisenstein administered a pulmonary function test during the examination. The study yielded a forced vital capacity of 65% of predicted and a one-second forced expiratory volume of 76% of the predicted normal value for someone of Mr. Almanzar's height and age. Dr. Eisenstein diagnosed the Claimant with chronic obstructive pulmonary disease and stated the Claimant's pulmonary disability is 35% of his total disability. During his deposition, Dr. Eisenstein testified that the Claimant suffers from a branch of chronic obstructive pulmonary disease called bronchitis. (CX 23). The physician further testified the Claimant suffers from only a 25% impairment according to the AMA guidelines. Dr. Eisenstein characterized the Claimant's pulmonary disability as permanent and attributed the permanent

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[1]The parties have stipulated that Dr. Eisenstein evaluated the Claimant's pulmonary condition on January 12, 1988 and prepared a report of the examination; however, the report is no longer in existence and is not part of the record in this proceeding.

pulmonary disability to Mr. Almanzar's work. (CX 18). The physician opined all of Mr. Almanzar's conditions, including uncontrolled diabetes, diabetic retinopathy, coronary artery disease, osteoarthritic changes in the cervical spine, and chronic obstructive pulmonary disease, have rendered Mr. Almanzar incapable of working in any occupation. In a December 23, 1994 addendum to the August 18, 1994 report, Dr. Eisenstein advised Mr. Almanzar to avoid further exposure to any of the "fumes and other deleterious substances" Dr. Eisenstein mentioned in his 1994 report; however Dr. Eisenstein never discussed Mr. Almanzar's exposure history in the 1994 examination report.

Dr. Armando Martinez examined Mr. Almanzar on November 6, 1995. (EX 1). On physical examination, Dr. Martinez noted tenderness of the paraspinal cervical muscle, no muscle spasm, and complete flexion and extension. He also noted some pain during lateral rotation and bending. The physician also found no muscle atrophy of the upper extremities and complete and painless range of motion in the upper extremities. Tenderness over the right shoulder was also noted. Examination of the lumbosacral spine showed a normal gait and some pain during all planes of motion. Dr. Martinez found no muscle atrophy in the upper extremities. Complete and painless range of motion in the shoulders was also noted. Dr. Martinez stated "[i]f the history given by Mr. Almanzar is factual, his complaints and findings could be very well related to the injury he sustained on 5/14/91." The physician opined that from an orthopedic standpoint, Mr. Almanzar has reached "the maximum benefits of medical care and no further treatment is necessary." The physician further opined the Claimant is capable of working from an orthopedic standpoint. Dr. Martinez estimated the Claimant suffers from a 2 1/2% total disability for all of his orthopedic injuries. A letter dated April 8, 1996, from Dr. Jack Siegel indicates he is of the opinion Mr. Almanzar can return to his job as a welder, from an orthopedic standpoint. The letter also has Dr. Martinez' name on it.

Dr. Ferretti evaluated Mr. Almanzar again on April 22, 1996. (CX 11). Dr. Feretti noted the Claimant was suffering from headache, dizziness, right shoulder pain, jaw pain, sleep disturbance, and depression. During his deposition, Dr. Ferretti testified Mr. Almanzar was unmotivated and apathetic. (CX 23, p. 19) The physician considered these findings to be symptoms of depression. The Claimant also reported suffering from occasional auditory hallucinations. The physician noted improvement in the Claimant's memory since the May 1993 examination. Dr. Feretti again diagnosed Mr. Almanzar with adjustment reaction of adult life with features of anxiety, depression, and phobia. He also stated neuropsychological dysfunction secondary to a closed head injury with loss of consciousness needed to be ruled out as a possible axis two diagnosis. The physician also diagnosed Mr. Almanzar with post-concussion headaches with dizziness, complaints of cervical and lumbosacral pain, and insulin dependent diabetes mellitus. Dr. Feretti commented that Mr. Almanzar continues to complain of severe psychiatric difficulties and little remission in his physical problems. The physician stated his diagnoses and recommendations are based on the assumption that the Claimant was accurate and truthful in his responses and narration. The physician opined it would not be reasonable for the Claimant to return to his former employment as a machine mechanic and welder given the Claimant's dizziness and subjective

complaints. Dr. Ferretti opined Mr. Almanzar is not a "feasible subject for vocational rehabilitation because of the longevity and severity of his physical and psychiatric illness and because he appears to have a completely under motivated attitude with respect to any type of employment." Dr. Ferretti further commented "the implication is that the patient's condition would worsen if he were stressed; however, since there is no objective study to quantify depression and other psychiatric entities, it is difficult to state with absolute certainty that this patient is categorically disabled; however, the evidence appears to point to this at this time."

Dr. Walter Castillo, a psychiatrist, treated Mr. Almanzar on May 29, 1996 and on four subsequent occasions. (CX 12). The Claimant reported the following symptoms to Dr. Castillo: depression, insomnia, headaches, irregular appetite, and forgetfulness. The physician also noted the Claimant was diabetic, taking insulin, and suffered from hypertension. Dr. Castillo diagnosed Mr. Almanzar with prolonged depressive disorder and prescribed Prozac, Ambien, and Buspar .

Dr. Mitchell Steinway conducted an orthopedic evaluation on the Claimant on August 6, 1996. (CX 14). Dr. Steinway is board-certified in orthopedic surgery. The physician reviewed extensive medical evidence of record in connection with his evaluation of Mr. Almanzar. The Claimant stated he was suffering from the following orthopedic complaints: neck pain and stiffness, lower back pain and stiffness, and right shoulder pain, stiffness, and weakness. Dr. Steinway diagnosed residual post-traumatic cervical spine sprain, probable cervical osteoarthritis, residual post-traumatic lumbar spine sprain, probable lumbar osteoarthritis, and a right shoulder rotator cuff tear. Dr. Steinway stated he was "aware" of the Claimant's pulmonary and psychiatric dysfunction, and a history of insulin-dependent diabetes mellitus and myocardial infarction. The physician stated that considering the above-noted medical problems, psychiatric problems, residual discomfort in the mandible, and the orthopedic dysfunction noted by him, Mr. Almanzar is totally and permanently disabled from returning to his usual work as a welder/longshoreman.

Medical records from Palisades General Hospital indicate Mr. Almanzar was hospitalized on October 22, 1998 for uncontrolled hypertension, diabetes mellitus, type I with renal insufficiency which appeared to be chronic, and anemia. Dr. G. Gastell also stated a myocardial infarction needed to be ruled out as a possible diagnosis. Dr. M. Bornia examined Mr. Almanzar on October 23, 1998 and stated Mr. Almanzar was suffering from azotemia, accelerated hypertension and symptoms suggestive of upper gastrointestinal bleeding. On November 2, 1998, the Claimant underwent an operation to create an arterial venous fistula in his right wrist. Mr. Almanzar was discharged from Palisades General Hospital on November 3, 1998. Dr. Gilberto Gastell's final diagnosis of the Claimant was as follows: uncontrolled hypertension, renal failure, diabetes mellitus type I, anemia, mitral regurgitation, tricuspid regurgitation, aortic regurgitation, left ventricular hypertrophy, left ventricular systolic dysfunction and coronary artery disease. The Claimant was admitted to the hospital again on November 19, 1998 for pulmonary edema, chest pain syndrome and shortness of breath with vomiting, and renal failure with coronary artery disease. Dr. Bornia examined the Claimant on November 19, 1998 and diagnosed congestive heart failure. The physician stated a fluid overload of a diabetic patient with diabetic

nephropathy, with significant advanced renal disease. He stated Mr. Almanzar presents with uremic symptoms of nausea, vomiting, and congestive heart failure, for which immediate dialysis arrangements were made. A portable chest x-ray taken on the same day was interpreted by Dr. Robert Port as showing acute pulmonary edema. A portable chest x-ray taken on November 21, 1998, was interpreted by Dr. Steven Leffler as showing resolving pulmonary edema. Dr. C. Alcorta diagnosed Mr. Almanzar with hypertensive cardiovascular disease, chronic renal failure, arteriosclerotic heart disease, possible diffuse coronary artery disease on December 21,1998. The physician stated the Claimant had no acute cardiorespiratory problem at that time, and indicated it was ok for the Claimant to undergo a laser treatment at Dr. Braunstein's office. Dr. Radu
Codel treated Mr. Almanzar at Palisades General Hospital on August 25, 1999 for chest pain. Dr. Maria Bornia diagnosed the Claimant with chronic renal insufficiency and dialysis-dependent diabetic nephropathy. She stated Mr. Almanzar was admitted to the hospital with chest pain suggestive of coronary insufficiency. A portable chest x-ray administered on August 26, 1999 showed no cardiopulmonary pathology according to Dr. Leffler. Dr. Eli Djebiyan evaluated Mr. Almanzar for chest pain during dialysis on August 27, 1999. He admitted the Claimant to Telemetry for further observation. The physician stated if Mr. Almanzar's enzymes remained negative and in light of the work-up for similar symptoms before, he was going to discharge the Claimant the next day and do further work, if necessary, as an outpatient. Dr. Djebiyan discharged Mr. Almanzar on August 27, 1999. Mr. Almanzar was also hospitalized during January 2000. Dr. Bornia diagnosed Mr. Almanzar with diabetic nephropathy, pulmonary edema, and azotemia during this hospital stay.

Dr. Steinway examined Mr. Almanzar again on January 4, 2000. (CX 14). Dr. Steinway diagnosed residual post-traumatic cervical spine sprain, probable cervical osteoarthritis, residual post-traumatic lumbar sprain, and probable lumbar osteoarthritis. The physician also noted the following non-orthopedic diagnoses: history of hypertension, insulin-dependent diabetes mellitus, diabetic retinopathy, and a psychiatric disorder. The physician opined Mr. Almanzar is totally and permanently disabled from his usual work as a welder/longshoreman. He stated he expects "no material improvement" in Mr. Almanzar's medical or orthopedic condition in the future. The physician attributed the Claimant's condition to the May 14, 1991 accident. On January 28, 2000, Dr. Steinway prepared a supplemental report after reviewing additional medical records concerning the Claimant. The physician arrived at the same conclusions set forth in the January 4, 2000 report.

Dr. Carl Friedman evaluated Mr. Almanzar on January 20, 2000. (EX 6). At the time of Dr. Friedman's examination Mr. Almanzar was totally blind due to diabetic retinopathy. The physician also noted the Claimant had gone into renal failure and renal shutdown requiring hemodialysis. A pulmonary function study administered during the examination yielded a forced vital capacity value of 61% of predicted and a one-second forced expiratory volume value of 65% of the predicted normal value for an individual of Mr. Almanzar's height and age. According to Dr. Friedman, the study revealed a moderate restrictive component with no evidence of obstruction. A chest x-ray showed mild cardiomegaly and was normal. The physician diagnosed Mr. Almanzar with insulin dependent diabetes mellitus with evidence of advanced retinopathy causing total blindness, renal failure secondary to

diabetic nephropathy, history of coronary artery disease, and history of myocardial infarction. Dr. Friedman stated a review of the Claimant's accident indicates he suffered various orthopedic injuries such as a residual post-traumatic cervical spine sprain, and cervical osteoarthritis, as well as a right rotator cuff tear syndrome.
The only pulmonary abnormality the physician noted was a mild to moderate reduction in forced vital capacity. Dr. Friedman apportioned 95% of the Claimant's disability to his diabetes mellitus resulting in renal failure and blindness. The physician stated 4% of the Claimant's disability is related to the May 14, 1991 accident and resulting orthopedic injuries. Dr. Friedman attributed
1% of the Claimant's disability to his reduced forced vital capacity, which the physician thought was most likely not secondary to intrinsic lung disease. He classified Mr. Almanzar's impairment as a Class II under the AMA guidelines. The physician stated the percent of the Claimant's disability due to his respiratory condition is clearly less than 10% because the overwhelming disability is secondary to diabetes mellitus, blindness, and renal failure.

Dr. Eisenstein examined Mr. Almanzar again on April 11, 2000. (CX 18). The physi-cian noted the Claimant worked at Brady Marine for four years. Dr. Eisenstein also stated Mr. Almanzar was exposed to noxious fumes and dusts, such as welding fumes, dirt, oil mist, solvents, exhaust fumes, coolants, and other irritating chemicals, during his employment as a welder at Brady Marine. At that time, the physician indicated Mr. Almanzar had been experiencing increasing shortness of breath on slight exertion and had a mucopurulent cough with expectoration. The physician reviewed Mr. Almanzar's medical history which included an October 1998 hospitalization for renal failure. Mr. Almanzar was undergoing kidney dialysis three times each week. According to Dr. Eisenstein, the Claimant's renal failure is related to his insulin dependent diabetes and is not related to the May 14, 1991 accident. Dr. Eisenstein's April 11, 2000 examination included a chest x-ray, a blood sugar test, an electrocardiogram, and a pulmonary function study. Scattered areas of expiratory wheezing were again noted on physical examination. A chest x-ray taken during the examination showed increased bronchovascular markings with heart enlargement. A pulmonary function study administered on the day of the examination yielded a forced vital capacity value which was 70% of predicted and a one-second forced expiratory volume of 73% of the predicted normal value for someone of Mr. Almanzar's age and height. Dr. Eisenstein reached the same conclusions with respect to the nature and extent of the Claimant's pulmonary disability. The physician reiterated Mr. Almanzar is permanently and totally disabled because of his psychiatric condition, orthopedic condition, and prior history of diabetes and myocardial infarction.

Dr. Steven L. Nehmer examined Mr. Almanzar on May 25, 2000. (EX 2). Dr. Nehmer is board-certified in orthopedic surgery. Mr. Almanzar complained of back, neck and right shoulder pain. On examination, Dr. Nehmer noted the Claimant complained of pain on palpation of the cervical musculature, but did not seem tender. The physician also noted tenderness at the right shoulder. The physician stated that throughout the examination, "Mr. Almanzar seemed] to exhibit far more subjective complaints than objective findings" and stated the Claimant seemed to be engaging in "symptom magnification." Dr. Nehmer did not feel the Claimant made a true effort to move his neck, back, or

shoulder. Dr. Nehmer diagnosed the Claimant with cervical strain, lumbar strain, and right shoulder strain and stated that he felt the Claimant sustained these injuries in the May 14, 1991 accident. Dr. Nehmer opined Mr. Almanzar had completely recovered from his injuries and requires no further testing or treatment. The physician further opined that from an orthopedic standpoint, Mr. Almanzar can perform the job of a welder.

Dr. William Head evaluated Mr. Almanzar's psychiatric condition on July 13, 2000. (EX 5). Dr. Head is board-certified in psychiatry and neurology. The physician noted the Claimant was not unconscious when he was treated at Elizabeth General Medical Center on May 14, 1991. The physician did not review Dr. Mendelson's neurological reports. He didn't review Dr. Castillo's psychological records. Notes two claimed suicide attempts, 1 in summer 1999 and another in late 1999. At the time of Dr. Head's examination, the Claimant was complaining of headaches; neck pain; low back pain; depression; dizziness; memory impairment; impairment of concentratio; loss of consciousness; right arm and leg pain; decreased vision in both eyes; nightmares; left-sided jaw pain; auditory and visual hallucinations; a fear of dying; and a fear of being hit by a car while crossing the street. The physician stated the claimant "attempted to deny, misrepresent and minimize his significant non-accident related medical problems and blames his reported inability to work on the May 14, 1991 injury, when, in fact, his diabetes-related kidney failure and vision loss, among other non-accident related conditions, prevent him from working. The physician stated the Claimant's "claimed auditory hallucinations are quite atypical and are clearly an attempt to simulate psychopathology, in an apparent attempt to support this claim." Dr. Head concluded "Mr. Almanzar's psychiatric examination revealed essentially normal findings, aside from his histrionic personality trains and his attempts to feign psychopathology and misrepresent his history...." Dr. Head diagnosed Mr. Almanzar with malingering and stated the Claimant was attempting to simulate psychopathology for the purposes of his claim. The physician also diagnosed a phase of life problem and opined the Claimant does not suffer from post traumatic stress disorder. The physician opined the Claimant sustained no permanent or psychiatric condition or disability related to the May 14, 1991 accident. He stated "whatever transient emotional complaints Mr. Almanzar may have initially experienced, as a result of the May 14, 1991 work injury, have objectively resolved without permanent psychiatric residuals." The physician commented the Claimant "attempted to simulate psychopathology and misrepresent his history, in an apparent attempt to support his claim." The physician opined the Claimant's histrionic personality traits are rooted in his early childhood experiences. Dr. Head concluded the Claimant does not suffer from a permanent psychiatric condition or disability related to the May 14, 1991 accident. The physician further opined any indication for further psychiatric treatment, medication, or work-up as related to the accident. The physician acknowledged the Claimant's original subjective psychiatric complaints were "likely due" to the May 14, 1991 accident. The physician found no reason to impose any psychiatric restrictions on the Claimant's ability to earn a living or engage in usual and customary activities and thought vocational guidance was not necessary. Dr. Head stated Mr. Almanzar

will not, in his opinion, experience any future worsening of his psychiatric status due to his work-related injury.

Dr. Ferretti also evaluated the Claimant's condition on October 17, 2000. (CX 11). Dr. Ferretti noted a "significant worsening" of Mr. Almanzar's physical condition. He noted the Claimant's renal condition related to diabetes mellitus had become significantly worse, the Claimant appeared to be confused, and had difficulty with memory and concentration. Mr. Almanzar was experiencing chronic pain and difficulty walking and showed evidence of neuropsychological and memory dysfunction. Dr. Feretti diagnosed Mr. Almanzar with chronic depression, anxiety, sleep disturbance, and phobia. The physician based his diagnosis of chronic depression on the Claimant's sleep disorder, lack of energy, lack of motivation, and depressed mood. (CX 23, pp 25-26). During his deposition, Dr. Ferretti testified the Claimant's memory dysfunction was "obviously problematic" on October 17, 2000 and thus the physician diagnosed a neuropsychological dysfunction secondary to a closed head injury with loss of consciousness rather than the possibility of such a condition. (CX 23, p. 24). The physician testified the Claimant suffers from moderate to severe stress because he suffers from a number of conditions. (CX 23, p. 28). According to Dr. Ferretti, the May 14, 1991 accident contributed to Mr. Almanzar's stress level. (CX 23, p. 28). Dr. Ferretti also diagnosed the Claimant with post-concussion headaches with dizziness, cervical and lumbosacral pain, insulin dependent diabetes mellitus, and diabetic nephropathy with chronic renal dysfunction. Dr. Ferretti stated Mr. Almanzar must be considered totally and permanently disabled for any meaningful employment due to his deterioration in physical condition which is secondary to non-accident related conditions such as diabetes mellitus, renal disease, coronary artery disease, and hypertension. Dr. Ferretti stated the Claimant's May 14, 1991 injuries must be considered a substantial cause of the Claimant's chronic depression although the physician thought the deterioration in the Claimant's physical condition was also meaningful from an etiological standpoint. Dr. Ferretti considered the Claimant to be permanently ill from a psychiatric standpoint and recommended psychiatric treatment and supervision. The physician rated Mr. Almanzar's level of functioning at 40 on a 100-point scale. Dr. Ferretti considered such a rating to be indicative of a very low level of functioning.

Dr. Mitchell Steinway was deposed on October 24, 2000. (CX 22). The physician first discussed his August 6, 1996 examination of the Claimant. Dr. Steinway noted the Claimant's neck was stiff on physical examination and the trapezius muscles between the Claimant's shoulders and neck were tender and had abnormal spasm or tightness of the muscle. (CX 22, pp. 8-9). The physician explained muscle spasms are an abnormal state of contraction of a muscle group and can last for weeks, months, or years. Dr. Steinway stated muscle spasms may be caused by nerve, spinal cord or head injuries, as well as local causes such as direct injury, an infection or a tumor. Dr. Steinway also testified Mr. Almanzar had clinical and historical complaints consistent with a tear of the right rotator cuff, a group of our tendons which help to control the motion of the shoulder. (CX 22, p. 10). The physician noticed the Claimant had atrophy on the right side of the deltoid muscle and the supraspinatus muscles. The physician explained a finding of atrophy indicates a patient's muscles either are not being used or are not being stimulated. According to Dr. Steinway, the causes of atrophy can be local, such

as when a person's joint hurts and the person will not move it, or distant, when nerves compress muscles
and they die away. (CX 22, p. 11). The physician stated approximately 50% of the Claimant's shoulder motion was missing in 1996. Dr. Steinway stated when he tried to move Mr. Almanzar's right arm out forward from Mr. Almanzar's torso, he could only lift the arm to 90
degrees, whereas a normal range of motion would be 180 degrees. Dr. Steinway noted that he considered the range of motion tests he performed on the Claimant to be accurate because they did not indicate the Claimant was restricting his ability to move his spine or shoulder in any position. (CX 22, p. 15). The physician noted localized tenderness and a complaint of pain on palpation in the area where the rotator cuff inserts into the top of the humerus. (CX 22, p. 12). On passive motion, the physician heard a crepitus or grinding sensation, which the physician opined is a sign of a rotator cuff disease or tear which was consistent with the five-year interval between the accident and the examination because such a finding usually develops after several years. The physician also noted a decreased curvature in the lumbar spine on physical examination. The physician explained that a finding of a straight spinal cord is consistent with osteoarthritis and/or cervical disk disease. He stated such a finding can be caused by muscle spasm or an arthritic change. The physician determined the Claimant had 50% loss of the normal lumbar motion for someone his age. Dr. Steinway noted Mr. Almanzar's reflexes were sluggish, which indicated he was having some early interference with the muscle group that was tested reflexively. (CX 22, p. 13). Dr. Steinway considered such a finding to be an early sign of nerve root compression. Dr. Steinway diagnosed the Claimant with residual post-traumatic cervical spine sprain, probable cervical osteoarthritis, residual post-traumatic strain of the lumbar spine, probable lumbar osteoarthritis, and right shoulder rotator cuff tear. (CX 22, p. 15). The physician explained a sprain is an "injury or force applied to ligaments, tendons, and muscles to disrupt the normal anatomy of that structure and to cause them to heal in an abnormal position that alters the mechanics of the joints involved. The physician stated a sprain results in a stretched or partially torn muscle which heals with scar tissue and may entrap nerve fibers, thus permanently altering the muscle and impairing the functioning of the muscle. (CX 22, p. 16). Dr. Steinway testified that Mr. Almanzar had pre-existing osteorarthritis of the spine because x-ray reports very close in time to the May 1991 accident showed radiological signs of osteoarthritis and because he noted findings consistent with osteoarthritis on clinical examination of the miner. Specifically, the physician stated that in his eighteen years of clinical experience, an individual who has restricted cervical spine motion, passively, in multiple planes; complaints of persistent neck pain; and a straightening of the cervical curvature or cervical lordosis, will have cervical osteoarthritic changes on x-ray. (CX 22, p. 17). Dr. Steinway stated the effect of a sprain can be different where an individual suffers from osteoarthritis of the cervical and lumbar spine. The physician explained osteoarthritis causes stiffness and resulting abnormal functioning of the back and neck. He stated if soft tissue abnormalities to muscles and ligaments are superimposed on the bony abnormalities, it will exacerbate and accelerate the disability or abnormal function that the individual already had from the bony injury. (CX 22, p.16-17). The physician concluded Mr. Almanzar's orthopedic conditions are permanent in nature and that the Claimant was permanently and totally disabled from an orthopedic standpoint for his usual work as a welder and a longshoreman. (CX 22, p. 17).

Dr. Steinway testified that he examined the Claimant again on February 10, 1998. (CX 22, p. 18). The physician noted the same physical findings he noted during the 1996 examination. The physician also noted an additional finding of atrophy in the left thigh versus the right thigh. (CX 22, p. 21). Dr. Steinway stated atrophy of the left thigh can be caused by a joint problem in the hip, knee, or ankle. The physician stated it was more likely the atrophy represented a mild nerve root compression in the sciatic area. Dr. Steinway noted the atrophy was only 1 centimeter which is the lowest amount that can be measured in the office, however, he felt atrophy was present. (CX 22, p. 22). The physician also noted the Claimant was walking with an abnormal gait. Mr. Almanzar was hunched over a bit with his torso bent forward about 20 degrees. The physician also noted a decrease in straight leg raising, and some bursal thickening around the right shoulder. Thus, Dr. Steinway testified there was a "small but definite degree of increased abnormal physical findings in 1998 versus 1996." Dr. Steinway made the same diagnoses he made during the 1996 examination. (CX 22, p. 23). The physician again opined Mr. Almanzar is totally and permanently disabled from his usual work activity as a welder and a longshoreman, noting that the Claimant's orthopedic condition was "essentially the same."

Dr. Steinway testified he also examined Mr. Almanzar on January 4, 2000. (CX 22, p. 24). The physician stated he found no significant changes concerning the cervical spine, thoracic spine, lumbar spine or right shoulder since the 1998 examination. (CX 22, p. 25). The physician's diagnoses and opinion as to the nature and extent of the Claimant's orthopedic disability stayed the same. The physician reviewed additional medical records on January 28, 2000, but those records did not alter his opinions. Dr. Steinway opined that the injuries the Claimant sustained during the May 1991 accident aggravated and accelerated the Claimant's pre-existing osteoarthritis of the neck and back; however, the physician noted the osteoarthritis was not symptomatic at the time of the injury. Dr. Steinway further opined the accident "aggravated and accelerated pre-existing cervical disk disease and osteoarthritis, causing it to become symptomatic and interfere with upper and lower extremity orthopedic function and also was the sole contributor to the severe injury of the right shoulder, causing the right shoulder to become dysfunctional." (CX 22, p. 27). Thus, Dr. Steinway concluded the orthopedic injuries are a substantial contributing factor to the Claimant's total orthopedic disability.

On cross-examination, Dr. Steinway distinguished the diagnosis of a patient from the assessment of a patient's disability, stating the two are independent. (CX 22, p. 30). He stated the history a patient gives him does not materially affect the amount of disability he will find because a finding of orthopedic disability is based on a patient's inability to perform certain maneuvers, i.e. walking, sitting, bending, moving a joint, etc. The physician stated his reports do not indicate and he does not recall the Claimant being uncooperative or exaggerating his condition. (CX 22, p. 33). When asked whether psychiatric medication Mr. Almanzar was taking would have affected his reflexes, Dr. Steinway stated he would have to know the exact medication because psychotropic medications generally do not dampen the peripheral reflexes of the arms and legs. (CX 22, p. 35). The physician stated the cervical spine injury could also affect the Claimant's arm reflexes. (CX 22, p. 36). He

explained if there is nerve compression of the sixth or seventh cervical nerve root, it will make the biceps and triceps reflexes at the elbow
sluggish. However, Dr. Steinway found no other evidence of nerve root compression in the cervical spine. He did not review the actual x-ray films upon which he based the osteoarthritis diagnosis. (CX 22, p. 39). The physician also was not aware of any MRI studies performed on the Claimant's cervical and lumbar spine.

Dr. Steinway acknowledged he is the only physician of record who diagnosed a right rotator cuff tear and stated the other orthopedic physicians missed the diagnosis. (CX 22, p. 42). The physician testified that he related the persistent muscle spasm to the Claimant's accident because the accident caused the injuries which caused aggravation and acceleration of the Claimant's disk disease and osteoarthritis and secondarily by nerve compression to various muscles.
(CX 22, pp. 47-48). The physician stated the muscle spasm is another symptom of nerve root compression because the atrophy of the deltoid and supraspinatus muscles could be caused by nerve root compression over time or by disuse of the muscle. (CX 22, p. 48). Dr. Steinway initially stated Mr. Almanzar's orthopedic conditions prevent him from working; however, the physician also stated that "from an orthopedic point of view, if a job could be structured so that he would not have any heavy lifting, he would be able to get up from a bench type situation ten minutes every hour to walk around and stretch, that he would not have to use his right upper extremity repetitively in an overhead manner, it is possible that some light duty job could be constructed" for the Claimant. (CX 22, pp. 51-52). The physician testified Mr. Almanzar had not met maximum medical improvement the last time he saw the Claimant; however, the physician also stated based on his experience, he does not suspect that Mr. Almanzar's condition is "going to improve to a degree that will allow him to perform as a working unit on a regular basis." (CX 22, p. 54). Dr. Steinway also stated the fact that Mr. Almanzar did not lose consciousness for a week during his hospital stay in May 1991 does not change any of his opinions with regard to the reliability of his examination or his findings and opinions. (CX 22, p. 57). The physician stated that assuming the Claimant declined any further medical treatment or testing with regard to his right shoulder, then the date of maximum medical improvement as to that injury would be the first time Dr. Steinway examined Mr. Almanzar on August 6, 1996. (CX 22, p. 58). The physician admitted it is possible that the Claimant could have reached maximum medical improvement prior to that date. (CX 22, p. 58).

Counsel for the Employer deposed Dr. Head on November 8, 2000. (EX 15). Dr. Head is board-certified in neurology and psychiatry. The physician stated the Claimant's psychiatric examination revealed essentially normal findings aside from some dramatic flares in his personality and aside from his attempting to use a history of hallucinations and delusions to feign psychopathology and his tendency to misrepresent his history regarding physical condition. Dr. Head explained his Axis One diagnosis of the Claimant was malingering, or a conscious attempt to simulate pathology in order to obtain substantial material gain. The physician identified several factors that are indicative of a malingerer: 1) medical/legal presentation of a case; 2) failure to participate in or cooperate during the

examination process; 3) presence of a sociopathic personality disorder; and 4) disparity between the examination findings and objective tests and
the patient's own claims. Dr. Head stated almost everyone satisfies criterion 1. As for criterion 2, he stated he could not say Mr. Almanzar met the criterion because Mr. Almanzar cooperated with him during the course of his examination. The physician also stated there's no evidence the Claimant spent time in jail or broke the law. According to Dr. Head, Mr. Almanzar clearly met criterion 4 because Mr. Almanzar repeatedly complains of neurological symptoms and emotional problems despite the fact that no evidence of such conditions has been revealed during examinations by other psychiatrists or during Dr. Head's examination. Dr. Head explained he also diagnosed the Claimant with a phase of life problem, which means Mr. Almanzar is appropriately concerned about his diabetes. Dr. Head's axis 2 diagnosis notes histrionic or dramatic personality traits manifested by a tendency to exaggerate and simulate psychopathology. The physician stated his axis three diagnoses refer to the Claimant's physical condition. Dr. Head's axis 5 diagnosis was based on everything the patient told him. Dr. Head testified the GAF rating of 70 was approximately normal rating. Dr. Head concluded the Claimant may have had some initial emotional complaints relative to his injury, but found no objective evidence of a persistent psychiatric condition from the injury. Dr. Head also concluded Mr. Almanzar is not disabled from a psychiatric standpoint. Dr. Head felt there was noted there was no need for Mr. Almanzar to resume psychiatric treatment. Dr. Head also identified the reports he reviewed from Dr. Mendelson and stated those reports confirm his conclusions. He noted Dr. Mendelson repeatedly noted the disparity between the Claimant's objective findings and subjective complaints. Dr. Head reviewed Dr. Castillo's September 5, 1996 report and stated the report indicated the Claimant had not been treated by Dr. Castillo since that time. Dr. Head further testified Dr. Feretti's April 22, 1996 report did not alter his conclusions. Dr. Head stated Dr. Feretti's approach was that "if the patient says it, it must be true unless we find differently or can prove differently." Dr. Head explained his Axis One diagnosis of the Claimant was malingering, or a conscious attempt to simulate pathology in order to obtain primary gain.

During his November 13, 2000 deposition, Dr. Eisenstein stated the Claimant's chronic obstructive pulmonary disease is a material contributing factor to his total disability. (CX 23). The physician testified Mr. Almanzar is totally disabled and can no longer work in any occupation. Dr. Eisenstein also attributed Mr. Almanzar's condition to his exposure to dirt, dust, fumes, and other noxious substances at Brady Marine. The physician stated prolonged exposure to welding fumes alone can cause chronic obstructive pulmonary disease. Dr. Eisenstein further testified such substances would have aggravated and accelerated Mr. Almanzar's preexisting condition. Dr. Eisenstein attributed the Claimant's condition to his employment at Brady Marine even though Mr. Almanzar worked as a welder for Union Dry Dock for approximately fifteen years and worked as a welder for Brady Marine for three to four years. On cross-examination, the physician attributed Mr. Almanzar's work-related pulmonary condition to his employment as a welder for both Union Dry Dock and Brady Marine. Dr. Eisenstein did not consider giving Mr. Almanzar a 10% impairment rating under the AMA guidelines

even though the Claimant was four points away from a normal reading.[2] Dr. Eisenstein relied upon Mr. Almanzar's history, physical examination, and x-ray in making such a determination. On cross-examination, Dr. Eisenstein was asked about the source of the exposure history listed in the 1994 report; however, as noted above, the 1994 report did not discuss the Claimant's occupational exposure history. Dr. Eisenstein also testified the accuracy of pulmonary function study values is not affected by the fact that a patient receives kidney dialysis or suffers from heart disease. Dr. Eisenstein opined Mr. Almanzar can perform other jobs, from a pulmonary standpoint, as long as the work environment is free from pulmonary irritants.

During his November 27, 2000 deposition, Dr. Ferretti opined the psychiatric problems he described are permanent in nature; however, he offered the caveat that there are many factors contributing to the Claimant's condition. The physician stated "there's no question [the Claimant] can do no work." The physician opined the May 14, 1991 accident is a substantial contributing factor in the Claimant's disability and his inability to return to work. Dr. Ferretti recommended further psychiatric treatment for the Claimant, including a neuropsychological battery. The physician also opined the May 14, 1991 accident is a substantial contributing factor to the Claimant's psychiatric problems, including his depression. The first time Mr. Ferretti evaluated the Claimant it was at the request of CIGNA; the second time it was at the request of the Claimant's counsel. The physician acknowledged putting the footnote in his second report because he was concerned about the Claimant's truthfulness. He stated he found the Claimant to be dramatic and histrionic. Dr. Ferretti admitted he thought malingering was "a major concern" in Mr. Almanzar's case. Dr. Ferretti stated Mr. Almanzar exhibited fewer behaviors consistent with malingering during his second evaluation of the Claimant. The physician explained the Claimant was soft spoken, was not histrionic, and stated he had fewer of the unusual symptoms Dr. Ferretti asked him about. Dr. Ferretti opined the Claimant's renal illness plays a substantial part in the Claimant's psychiatric disability. The physician did not feel he could apportion the Claimant's disability to his various conditions because it would be speculative to do so. The physician opined that if Mr. Almanzar only suffered from his non-work-related illnesses, he thinks the Claimant would still be disabled from a psychiatric standpoint. On re-direct examination, the physician states the deterioration in the Claimant's non-work-related conditions occurred after his first examination in 1996 and that he thought the Claimant was disabled from a psychiatric standpoint in the 1996 evaluation. The physician then admitted he did not categorically conclude the Claimant was disabled from a psychiatric standpoint. He did state, however, that Mr. Almanzar could not work as a painter or welder because of his depression.

Counsel for the Employer deposed Dr. Nehmer on December 1, 2000. (EX 14). Dr. Nehmer is board-certified in orthopedic surgery. The physician testified he performed an examination on the Claimant on May 25, 2000. The physician testified his clinical examination of the Claimant focused upon his neck, back and right shoulder. Based on his review of the records,

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[2]The AMA guidelines provide that in terms of a one-second forced expiratory volume, the 10-25% disability classification encompasses FEV1 values from 60-79% of predicted.

the physician stated the Claimant's ability or range of motion he exhibited in his neck was not consistent with the injuries he sustained in the work accident. Dr. Nehmer stated he has seen patients with neck fractures, multiple disk herniations and neck tumors who are able to move their necks more than Mr. Almanzar did. He stated there is "really almost no explanation of having that little motion in your neck." Dr. Nehmer also noted he found no atrophy in the Claimant's upper or lower extremities. The physician explained problems in the neck can result in atrophy in the upper extremities and problems in the back can result in atrophy in the lower
extremities. The physician found Mr. Almanzar to have better than average muscle tone in his body. He stated if one has a significant los of motion and the amount of pain Mr. Almanzar was exhibiting, the person would be expected to have a very significant amount of atrophy because one would not use an extremity if he or she could not do so. Dr. Nehmer found no spasm on neck palpation and stated he would only expect to find such weeks or possibly even months after an injury, but not years afterward. Dr. Nehmar reiterated his diagnoses of cervical strain, lumbar strain, and right shoulder sprain caused by the 1991 accident. The physician opined the Claimant had completely recovered from those injuries. Dr. Nehmer concluded the Claimant could work as a welder from an orthopedic standpoint. The physician indicated he considered the work of a
welder to be "heavy" work. Dr. Nehmar stated the Claimant requires no further testing or treatment for his orthopedic injuries. The physician didn't record the results of other range of motion tests such as the tests for flexion, extension, and tilt. Dr. Nehmer noted his report references a right shoulder strain rather than sprain, but stated it should have read right shoulder sprain. Dr. Nehmer explained a sprain is of a ligament whereas a strain is of a muscle; however, he stated both terms refer to a soft tissue injury. Dr. Nehmer did not perform tests of internal and external rotation on the right shoulder and these tests are some of the clinical tests used to determine whether someone has a tear of the rotator cuff. Dr. Nehmer admitted not everyone who has subjective complaints without objective findings is guilty of symptom magnification. The physician explained that he thought Mr. Almanzar was engaging in symptom magnification because of the way he described his injuries, the way he attempted to move various body parts when asked to do so, the Claimant's facial expressions, his reactions when Dr. Nehmer touched him in certain places, i.e., saying it hurts a lot, but no involuntary motion or reflex facial reaction one would normally get with a person who has just experienced something painful to them. Dr. Nehmer did not suspect the Claimant had a torn right rotator cuff. He stated if an orthopedist suspects a torn rotator cuff, the physician should order a diagnostic test such as an MRI to determine the presence of such a condition. He stated a diagnosis of a torn rotator cuff cannot be made without the benefit of a diagnostic test. Dr. Nehmer stated he saw no evidence of decreased lordosis or nerve root compression in the cervical or lumbar spine. Dr. Nehmer examined the Claimant without the benefit of any diagnostic films, but stated a cervical spine x-ray in the Elizabeth General Medical records and a lumbar spine x-ray in Dr. Hutter's June 17, 1991 report did not change his opinions.

Counsel for the Employer deposed Dr. Friedman on December 4, 2000. (EX 16). Dr. Friedman testified he obtained the Claimant's histories from the transcript of the Claimant's deposition. Dr. Friedman stated that he noted no wheezes, rales or a prolonged expiratory phase during his examination of the Claimant. The physician explained that a person who has rales has a fairly significant

obstruction, although he acknowledged a person can have an obstruction without rales. Dr. Friedman also administered a pulse oximetry test during the January 2000 examination to determine the level of oxygen saturation in the Claimant's hemoglobin. Mr. Almanzar's saturation was 98% of predicted, or normal, according to Dr. Friedman. Dr. Friedman stated the fact that Mr. Almanzar's saturation was 98% excludes the possibility of respiratory insufficiency. The physician also administered a pulmonary function study which showed a restrictive defect rather than an obstructive defect. Dr. Friedman stated an individual with Mr. Almanzar's type of occupational exposure can suffer from chronic obstructive lung disease, an impairment which Dr. Friedman considers to be obstructive in nature rather than restrictive. Dr. Friedman stated the Claimant's forced vital capacity values could be the result of the fluid overload on his lungs due to his prior pulmonary edema. Dr. Friedman noted a reduction in forced vital capacity occurs when people have interstitial lung disease and that interstitial lung disease must be diagnosed by chest x-ray. Dr. Friedman interpreted the Claimant's chest x-ray as showing no evidence of interstitial fibrosis or pulmonary edema. He found no pleural disease and no pleural effusion. Dr. Friedman stated Dr. Eisenstein's August 18, 1994 pulmonary function study does not indicate the presence of chronic obstructive pulmonary disease because the indices that show obstruction, particularly the FEF value, were normal. Dr. Friedman explained the FEF represents the flow rates in the mid lungs and that Mr. Almanzar's flow rate was 103% of predicted. Dr. Friedman explained the FEV1/FVC "is another indice (sic) of obstruction" and stated Mr. Almanzar's ratio was 94.39 which does not indicate obstruction. (Tr. 16). Dr. Friedman stated the Claimant has a mild chest restriction according to Dr. Eisenstein's 1994 pulmonary function study. The physician stated the FEV1 value reported on Dr. Eisenstein's study of 76% of predicted is not an indication of chronic obstructive pulmonary disease. He explained that the percentage and not the FEV1 value itself determines whether an individual has an obstruction. During his deposition, Dr. Friedman reviewed an April 11, 2000 pulmonary function study and again opined the Claimant does not suffer from chronic obstructive lung disease. Dr. Friedman explained all of the Claimant's flow rates were normal, but acknowledged the Claimant had a reduced FEV1. Dr. Friedman stated at any time the fluid overloads within the Claimant's lungs would alter the forced vital capacity value. The physician stated that in his opinion, Mr. Almanzar's exposures from his work as a welder did not cause obstructive lung disease. Dr. Friedman stated that from a respiratory standpoint, Mr. Almanzar would be able to do moderate to strenuous work, provided he did not suffer from all of the other conditions he has. Dr. Friedman opined the Claimant is disabled from working when all of his conditions are considered. Dr. Friedman also reviewed records from Palisades General Hospital documenting Mr. Almanzar's October 1998 hospitalization. Dr. Friedman testified Mr. Almanzar does not need any medical treatment for a work- related pulmonary condition.

On cross-examination, Dr. Friedman explained that Mr. Almanzar's varying degrees of fluid overload result in his reduced forced vital capacity values. Dr. Friedman admitted he had no information indicating Mr. Almanzar had a problem with fluid overload in 1994, the year of Dr. Eisenstein's first pulmonary function study. Dr. Friedman stated welding fumes can cause obstruction and in high enough concentrations can also cause restriction. The physician stated that had Mr. Almanzar ended his welding career because he could not breathe, there would be a very strong case

that the fumes caused a disability; however, Dr. Friedman noted Mr. Almanzar's welding career was terminated due to the accident and not breathing problems. Dr. Friedman stated the percentage of the Claimant's total disability that is attributable to his respiratory condition is less than 10%. Dr. Friedman attributed the Claimant's respiratory disability not to the Claimant's lung disease but to the varying fluid overloads in an individual who undergoes dialysis. Dr. Friedman testified that clinically, on pulmonary function studies, Mr. Almanzar shows a moderate restrictive lung disease. Dr. Friedman stated he cannot identify, with a reasonable degree of medical certainty, the cause of Mr. Almanzar's restrictive lung disease in 1994.

Vocational Evidence

Charles Kincaid, Ph. D., CRC, ATP, performed a vocational evaluation and earning capacity analysis on Mr. Almanzar on October 31, 2000. (CX 21). In a report dated November 8, 2000, Mr. Kincaid concluded that prior to the May 14, 1991 accident, Mr. Almanzar had the capacity to perform 592 of the 1,949 most frequently hired for jobs in the state of New Jersey in 2000. The pre-injury job matches included 8 clerical/sales positions, 4 agricultural positions, 93 processing positions, 161 machine trade positions, 163 bench work positions, 58 structural positions and 42 miscellaneous jobs. Mr. Kincaid determined that Mr. Almanzar's profile did not match any of these job titles after the injury, thus indicating "total elimination of personal access to the labor market." Mr. Kincaid stated such a finding is consistent with the Claimant's severely diminished functional capacities of his back, neck, shoulder, eyesight, and stamina, combined with the Claimant's continuing medical involvement, educational level and work history. Mr. Kincaid stated Mr. Almanzar is not a good candidate for deriving benefit from vocational rehabilitation services because he is not medically stable and does not have the capacity to work an 8 hour day. Mr. Kincaid stated Mr. Almanzar experiences functional limitations in the area of eyesight, sitting, bending, kneeling, and stooping. Mr. Kincaid indicated the Claimant's daily functioning may be somewhat improved by the use of assistive technology devices; however, he opined the devices will not enable the Claimant to return to work as a welder. For Mr. Almanzar's sitting limitation, Mr. Kincaid noted a back support pillow or an ergonomic chair is an option which may alleviate discomfort and extend sitting time. Mr. Kincaid also recommended hand-operated reachers to extend the Claimant's ability to reach and retrieve objects or a specially designed desk or work area that places materials and objects within easy reach for use by a person with a limited range of motion. In regard to the Claimant's blindness, Mr. Kincaid did not think the Claimant was a good candidate for learning braille, considering the Claimant's advanced age; however, he noted there are a variety of devices that could assist Mr. Almanzar in his daily functioning. With respect to Mr. Almanzar's wage-earning capacity, Mr. Kincaid stated the Claimant's limited education, seriousness of his functional impairments and limited job experience would severely restrict the Claimant's ability to compete for jobs in the New Jersey labor market. Mr. Kincaid reiterated that Mr. Almanzar's occupational base has been realistically eliminated as a consequence of his injuries and resultant physical/functional impairments. Mr. Kincaid concluded the Claimant's wage earning power has also been eliminated.

CONCLUSIONS OF LAW

Jurisdiction/Coverage under the Act

In order for a claim to be covered by the Act, a claimant must establish that his injury occurred upon the navigable waters of the United States, including any adjoining pier, wharf, dry dock, terminal, building way, marine railway, or other adjoining area customarily used by an employer in loading, unloading, repairing, dismantling, or building a vessel. 33 U.S.C. §§ 902(3) and 903(a). In addition to satisfying this situs test, a claimant must also satisfy the status requirement by showing that his work is maritime in nature and not specifically excluded by the Act. *See* 33 U.S.C. § 902(3), 903(a); *Director, OWCP v. Perini North River Associates*, 459 U. S. 297 15 BRBS 62 (1983); *P.C. Pfeiffer Co. v. Ford*, 444 U. S. 69, 11 BRBS 320 (1979); *Northeast Marine Terminal Co. v. Caputo*, 432 U. S. 249, 6 BRBS 150 (1977). Thus, the situs test limits the geographic coverage of the Act, while the status test is an occupational concept that focuses on the nature of the worker's activities. *See Bienvenu v. Texaco, Inc.*, 164 F. 3d 901 (5th Cir. 1999)(en banc). Even though a longshoreman may be performing maritime work at the time of the injury, if the longshoreman is not injured within the land area specified by the LHWCA, he is not covered by the Act. *See Jonathan Corp. v. Brickhouse*, 142 F. 2d 217, 222 (4th Cir. 1998).

Brady Marine concedes Mr. Almanzar was engaged in maritime employment at the time of the May 14, 1991 accident, and thus has satisfied the status requirement for jurisdiction under the Act. However, Brady Marine contends I lack jurisdiction over Mr. Almanzar's traumatic injury claim because the May 14, 1991 accident did not occur at a situs covered by the Act. As discussed above, the Act's definition of a "situs" includes not only navigable waters but also "any adjoining pier, wharf, dry dock terminal, building way, marine railway, or other adjoining area customarily used by an employer in the shipbuilding process." 33 U.S.C. § 903(a). Specifically, Brady argues the Trumbull Street Facility at which the Claimant was injured is not an "adjoining area" within the meaning of Section 3(a). The situs inquiry focuses on the relationship between the Trumbull Street Facility and the nearest navigable waterway. *See Lasofsky v. Tickle Eng'g Works, Inc.*, 20 BRBS 58, 60 (Oct. 28, 1987), *aff'd* 853 F. 2d 919 (3d Cir. 1988).

The Benefits Review Board has considered the following factors in determining whether a site is an adjoining area within the meaning of the Act: 1) the particular suitability of the site for maritime uses referred to in the Act; 2) whether adjoining properties are devoted primarily to uses in maritime commerce; 3) the proximity of the site to the waterway; and 4) whether the site is as close to the waterway as is feasible given all the circumstances in the case. *See Lasofsky*, 20 BRBS, at 60 (citing *Brady-Hamilton Stevedore Co. v. Herron*, 568 F. 2d 137 (9th Cir. 1978)); *Arjona v. Interport Maintenance Co.*, 31 BRBS 86, 87-88 (1997).

Brady contends a weighing of these factors indicates the Trumbull Street facility was not an adjoining area within the meaning of the Act and thus was not a situs covered by the Act. Contrary to the Employer's assertions, I find a weighing of these factors establishes that Mr. Almanzar was injured at a situs covered by the Act. Although the evidence of record does not indicate the Trumbull Street Facility was particularly suited for maritime purposes, the evidence clearly establishes that the proximity of the Trumbull Street Facility to Port Elizabeth gave Brady Marine an economic advantage over other ship repairing businesses which are located further from Port Elizabeth. During 1991, the Trumbull Street Facility was used by Brady Marine in the process of repairing vessels. (Tr. 67). Daniel Muirhead, the current vice-president of Brady Marine, testified that in 1991, 75% of Brady Marine's work involved the repair of vessels docked in Port Elizabeth while approximately 25% of the corporation's work involved other pier facilities around the world. (Tr. 68). Mr. Muirhead further testified Brady Marine's repair shop is integral to its ship repairing business and that Brady Marine employees repaired vessels at Port Elizabeth and at the Trumbull Street Facility. (Tr. 69, 74, 89). Mr. Almanzar testified he performed the majority of his repair work on ships docked at the port. (Tr. 90). The parties disagree as to the distance between the Trumbull Street Facility and Port Elizabeth by car. Mr. Almanzar contends the driving distance between the two locations is approximately one and three-fourths miles. (Tr. 20). Mr. Muirhead stated the driving distance between the two locations is approximately four and two-tenths miles. (Tr. 100). Mr. Muirhead testified the distance by air between the Trumbull Street Facility and Port Elizabeth is less than one mile. (Tr. 95). I note that Section 903(a) of the Act does not require that the adjoining facility be exclusively or even primarily used for maritime purposes, or that the facility be within a specified distance to the shore before it will be considered a situs covered under the Act. *See Perkins v. Marine Terminals Corp.*, 673 F. 2d 1097 (9th Cir. 1982). Regardless of whether the Trumbull Street Facility was 1.75 miles or 4.2 miles driving distance from Port Elizabeth, the facility was close enough to the waterway to give Brady Marine an economic advantage over its competitors who were located further away from the port. Brady Marine employees traveled to and from Port Elizabeth to repair vessels at the dock and to transport parts back to the Trumbull Street Facility for repair. Although some of the parts were somewhat mobile in nature, the proximity of the Trumbull Street Facility to Port Elizabeth obviously was an important factor, despite Mr. Muirhead's testimony to the contrary, because 75% of Brady Marine's repair work involved ships in Port Elizabeth and because Brady Marine's repair facility was integral to its ship repairing business.

Another factor which weighs in favor of a finding of jurisdiction under the Act is the fact that some of properties located on the way from the Trumbull Street Facility to Port Elizabeth are maritime in nature. (Tr. 93). Specifically, Mr. Muirhead testified there are a number of trucking companies that transport containers to and from the port which are located between the Trumbull Street Facility and the entrance to the Sea-Land Terminal at Port Elizabeth. (Tr. 96). Mr. Muirhead testified there were non-maritime commercial and resi- dential properties near the Trumbull Street Facility; however, Mr. Muirhead stated that, with the exception of some residential areas on Dowd Street, the areas north and east of the Trumbull Street Facility are "all commercial." (Tr. 92). I note that Port Elizabeth is also northeast of the Trumbull Street Facility. (EX 17). The non-maritime

commercial businesses are located to the north, and east of the Trumbull Street Facility and residential properties are located south, west and northwest of theTrumbull Street Facility on the Hagstrom Map submitted by the Employer at
the hearing. (EX 17; Tr. 91-96). Moreover, the Trumbull Street Facility was adjacent to the E-Rail railroad yards operated by Conrail. (EX 17). Mr. Muirhead testified that the yard is part of the port where containers are received by rail for transfer to and from ships. (Tr. 93-94).

The individual who owned Brady Marine when the company was operating out of the Trumbull Street Facility is now deceased. Neither the Claimant nor the Employer knows what motivated the previous owner of Brady Marine to choose the Trumbull Street location. (Tr. 79). Therefore, it is difficult to determine whether the Trumbull Street Facility was as close to the waterway as possible, given all of the circumstances. Mr. Muirhead testified that as an employee of the former owner of Brady Marine, the former owner expressed concern to Mr. Muirhead about moving the company from the Trumbull Street Facility to the pier because of the increased cost of rent on the pier. (Tr. 79). Such testimony, even if credible, offers no insight as to why the former owner initially chose the Trumbull Street Facility. Nevertheless, for the reasons discussed above, I find that consideration of all of the facts and circumstances, including the four factors discussed above, requires a finding of jurisdiction under the Act.

Injury Arising Out of and in the Course of Employment

The parties have stipulated that Mr. Almanzar sustained injuries arising out of and in the course of his employment as a result of the May 14, 1991 accident. However, Mr. Almanzar also alleges he suffers from an occupational pulmonary condition caused by exposure to dust fumes, asbestos, and other deleterious fumes and substances while employed at Brady Marine. A person seeking benefits under the LHWCA has the burden of persuasion by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 114 S. Ct. 2241, 28 BRBS 43 (1994). In determining whether Mr. Almanzar has sustained an injury compensable under the Act, I must consider the relationship between Sections 2(2) and 20(a) of the Act. Section 2(2) of the LHWCA defines "injury" as:

> accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally and unavoidably results from such accidental injury, and includes injury caused by the willful act of a third person directed against an employee because of his employment.

33 U.S.C. § 902(2).

In occupational disease cases, there is no "injury" until the accumulated effects of the harmful substance manifest themselves and the claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware, of the relationship between the

employment, the disease, and the disability. *Travelers Ins. Co. v. Cardillo*, 225 F. 2d 137 (2d Cir. 1955), *cert. denied* 350 U.S. 913 (1955); *Thorud v. Brady-Hamilton Stevedore Co., et al.*, 18 BRBS 232 (1987); *Geisler v. Columbia Asbestos, Inc.*, 14 BRBS 794 (1981). The Act does not require that the injury be traceable to a definite time. The fact that a claimant's injury occurred gradually over a period of time as a result of continuing exposure to conditions of employment is no bar to a finding of an injury within the meaning of the Act. *Bath Iron Works Corp. v. White*, 584 F. 2d 569 (1st Cir. 1978).

Section 20(a) of the Act, 33 U.S.C. § 920(a), creates a presumption that a claimant's disabling condition is causally related to the claimant's employment. In order to invoke the Section 20(a) presumption, a claimant must first establish a prima facie claim for compensation under the Act. *See Kelaita v. Triple A Mach. Shop*, 13 BRBS 326, 330-31 (1981), *aff'd sub nom. Kelaita v. Director, OWCP*, 799 F. 2d 1308 (9th Cir. 1986); *Kier v. Bethlehem Steel Corp.*, 16 BRBS 128 (1984). The claimant must show he or she sustained physical harm or pain and that an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. *See Merrill v. Todd Pacific Shipyards Corp.*, 25 BRBS 140 (1991); *Stevens v. Tacoma Boat Bldg. Co.*, 23 BRBS 191 (1990). If a claimant establishes a prima facie case, the claimant's injury is presumed to have arisen out of the claimant's employment under Section 20(a). I note this statutory presumption neither dispenses with the requirement that a claim of injury be made in the first place nor is it a substitute for the evidence required to establish a prima facie case. *See generally, U.S. Indus./Fed. Sheet Metal v. Director, OWCP*, 455 U.S. 608 (1982), *rev'g Riley v. U.S. Indus./Fed. Sheet Metal*, 627 F. 2d 455 (D.C. Cir. 1980). Once the presumption is invoked, the burden of production then shifts to the employer to establish the claimant's injury was not caused or aggravated by the claimant's employment. *See Brown v. Pacific Dry Dock*, 22 BRBS 284 (1989); *Rajotte v. General Dynamics Corp.*, 18 BRBS 85 (1986). The Section 20(a) presumption can only be rebutted by substantial countervailing evidence that the claimant's injury was not caused by his employment. *See Sinclair v. United Food & Commercial Workers*, 23 BRBS 148, 154 (1989). If the employer successfully rebuts the presumption, it no longer controls, and I must look at all of the evidence of record to determine whether the claimant's injury arose out of and in the course of his employment with the employer. *See, Del Vecchio v. Bowers*, 296 U.S. 280 (1935); *Volpe v. Northeast Marine Terminals*, 671 F. 2d 697 (2d Cir. 1982).

Prima Facie Case

To establish a prima facie claim for compensation, Mr. Almanzar need not affirmatively establish a nexus between his employment and the harm he alleges he has suffered. Rather, Mr. Almanzar must establish only that he sustained physical harm or pain and that an accident occurred in the course of employment, or working conditions existed, that could have caused the harm or pain. *See Clophus v. Amoco Prod. Co.*, 21 BRBS 261, 265 (1988). A claimant's credible subjective complaints of symptoms and pain can constitute sufficient proof of the requisite physical harm and the invocation of the 20(a) presumption. *See, Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236

(1981), *aff'd sub nom., Sylvester v. Director, OWCP*, 681 F. 2d 359 (5th Cir. 1982). However, the claimant's theory as to how the alleged injury occurred must go beyond "mere fancy." *See Champion v. S & M. Traylor Bros.*, 690 F. 2d 285, 295 (D.C. Cir. 1982).

In support of his allegation of an occupational pulmonary condition, Mr. Almanzar has offered the medical opinion of Dr. Bernard Eisenstein, a physician who is board-certified in internal medicine. Dr. Eisenstein examined Mr. Almanzar on three occasions.[3] Dr. Eisenstein diagnosed Mr. Almanzar with chronic obstructive pulmonary disease. Specifically, the physician diagnosed Mr. Almanzar with bronchitis, a type of chronic obstructive pulmonary disease. In an April 11, 2000 report, Dr. Eisenstein stated Mr. Almanzar was exposed to noxious fumes and dusts, such as welding fumes, dirt, oil mist, solvents, exhaust fumes, coolants, and other irritating chemicals, during his employment as a welder at Brady Marine. During the December 12, 2000 hearing, Mr. Almanzar testified he worked in closed rooms on ships during his employment with Union Dry Dock, Bethlehem Steel, and Brady Marine. (Tr. 35). The Claimant stated other workers around him would be burning with acetylene torches which would produce a lot of smoke. (Tr. 36). Mr. Almanzar wore a paper mask while working as a welder, but stated he breathed in a lot of the smoke and the welding fumes. (Tr. 36). Dr. Eisenstein attributed the Claimant's pulmonary condition to the Claimant's exposure to dirt, dust, fumes, and other noxious substances at Brady Marine. The physician stated prolonged exposure to welding fumes alone can cause chronic obstructive pulmonary disease. Dr. Eisenstein based his diagnosis of chronic obstructive pulmonary disease on the Claimant's physical findings, pulmonary function study, and chest x-ray. I find Dr. Eisenstein's opinions sufficient to establish that Mr. Almanzar sustained physical harm to his respiratory system while working at Brady Marine and that Mr. Almanzar was exposed to welding fumes which could have caused the respiratory injury from which he suffers. Thus, Mr. Almanzar has established a prima facie case of injury under the Act.

Rebuttal Evidence

Because I have found the evidence sufficient to invoke the Section 20(a) of the Act, I presume Mr. Almanzar's occupational disease was related to his employment at Brady Marine. Brady Marine may rebut this presumption by presenting "substantial evidence" which either proves the absence of, or severs the connection between, the Claimant's harm and the conditions in which he worked at Brady Marine. "Substantial evidence" is the kind of evidence a reasonable mind might accept as adequate to support a conclusion. *See*, *Noble Drilling Co. v. Drake*, 795 F. 2d 478 (5th Cir. 1986); *Travelers Ins. Co. v. Belair*, 412 F. 2d 297 (1st Cir. 1969). In evaluating the medical evidence, I am entitled to weigh the evidence and draw my own inferences from it, and I am not bound to accept the opinion or theory of any particular medical examiner. *See Todd Shipyards v. Donovan*, 300 F. 2d 741 (5th Cir. 1962).

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[3]The parties have stipulated that Dr. Eisenstein evaluated the Claimant's pulmonary condition on January 12, 1988 and prepared a report of the examination; however, the report is no longer in existence and is not part of the record in this proceeding.

Brady Marine has submitted an examination report and deposition testimony from Dr. Carl Friedman to rebut Mr. Almanzar's allegation of an occupational pulmonary condition. Dr. Friedman is board-certified in internal medicine. (EX 12). Dr. Carl Friedman examined Mr. Almanzar once on January 20, 2000. (EX 6). Dr. Friedman diagnosed a mild to moderate reduction in the Claimant's forced vital capacity and stated the reduction was "most likely not secondary to intrinsic lung disease." The physician found no evidence of obstruction.

During his December 4, 2000 deposition, Dr. Friedman opined that Mr. Almanzar does not suffer from chronic obstructive lung disease because the physician found the Claimant's impairment to be restrictive in nature rather than obstructive. (EX 16). Dr. Friedman thoroughly explained the basis for his opinion as to the absence of an obstructive impairment. The physician stated he found no wheezes, rales, or a prolonged expiratory phase that would clearly be defined as obstructive. (EX 16, p. 8). Dr. Friedman also conducted a pulse oximetry test during the examination which showed the Claimant's hemoglobin was 98% saturated with oxygen. (EX 16, p. 10). The physician stated the 98% saturation level excluded the possibility of respiratory insufficiency, but acknowledged that a saturation level below 90% would require a physician to consider the possibility of a chronic or severe pulmonary problem. (EX 16, p. 11). Dr. Friedman administered a pulmonary function study during his January 20, 2000 evaluation of
the Claimant. The physician stated the test yielded a forced vital capacity of 61% of predicted and that all of the other parameters were normal. The physician concluded such results indicated a restrictive impairment was present. Dr. Friedman explained the FEV1/FVC ratio was 87%. Dr. Friedman stated that if Mr. Almanzar's impairment were obstructive in nature, the ratio would have been below 75%. (EX 16, p. 12). Dr. Friedman testified that pulmonary edema or varying degrees of pulmonary vascular congestion can result in a reduced forced vital capacity value. The physician noted the Claimant had a history of pulmonary edema which required hospitalization and concluded the decreased forced vital capacity values in 2000 could have been caused by the fluid overloads in the Claimant's lungs. (EX 16, p. 13). Dr. Friedman explained the pulmonary function study administered during his examination of the Claimant was administered during a period when the Claimant was undergoing dialysis. He stated individuals gain and lose weight between dialyses which results in an increase in peripheral edema as well as an increase in pulmonary fluid in the lungs. Dr. Friedman also explained a reduced forced vital capacity value can be caused by interstitial lung disease, a condition that the physician thought has to be diagnosed by a finding of pulmonary fibrosis on chest x-ray. Dr. Friedman found no evidence of interstitial fibrosis on the chest x-ray he interpreted.

During his deposition, Dr. Friedman also explained why Dr. Eisenstein's August 18, 1994 pulmonary function study does not establish the presence of chronic obstructive pulmonary disease. (EX 16, p. 15). The physician explained the most sensitive value to an obstruction is the FEF value. Dr. Friedman stated Mr. Almanzar's FEF on the 1994 study was 103% of the predicted normal value. (EX 16, p. 16). The physician also stated the FEV1/FVC value also indicates obstruction. Mr. Almanzar's ratio was 94.39%, which meant Mr. Alamanzar breathed out 94.39% of his total forced vital capacity in one second. Dr. Friedman stated such a ratio does not indicate an obstruction. Dr.

Friedman acknowledged Mr. Almanzar has a reduced FEV1 value, but stated the FEV1 value is a function of the Claimant's total lung capacity. (EX 16, p. 17). The physician explained that if an individual has a total reduction in forced vital capacity, the individual's FEV1 value will also be reduced. The physician stated it is the FEV1/FVC ratio that indicates whether an individual has a pulmonary obstruction. Dr. Friedman also disagreed with Dr. Eisenstein's opinion that a finding of increased bronchovascular markings on chest x-ray supports a diagnosis of chronic obstructive pulmonary disease. (EX 16, p. 18). Dr. Friedman stated a finding of increased bronchovascular markings is a "very nonspecific" finding. According to Dr. Friedman, increased bronchovascular markings can occur in individuals who have pulmonary congestion for any reason. He stated a diagnosis of chronic obstructive pulmonary disease must be made by pulmonary function tests, unless an individual suffers from advanced emphysema, which, according to Dr. Friedman, would be obvious on a chest x-ray. (EX 16, p. 19). Because Dr. Friedman thoroughly explained how the medical findings support his diagnosis of a restrictive impairment rather than Dr. Eisenstein's diagnosis of an obstructive impairment, I find Dr. Friedman's opinion constitutes substantial evidence to rebut the presumption that Mr. Almanzar's pulmonary condition arose out of and in the course of his employment with Brady Marine.

Industrial Causation

Because Brady Marine has rebutted the Section 20(a) presumption, I must now look at all of the evidence of record to determine whether Mr. Almanzar has established that he suffers from an injury within the meaning of the Act. Prior to the United State's Supreme Court's opinion in *Director, OWCP v. Greenwich Collieries, (Maher Terminals)*, 512 U.S. 267 (1994), the "true doubt" rule applied to the adjudication of benefits claims under the Act. The rule required a factfinder to resolve doubtful questions of fact in favor of an injured employee. *See Parsons v. Director, OWCP*, 619 F. 2d 38, 41 (9th Cir. 1980). Thus, the true doubt rule placed a less stringent burden of proof on a claimant than the preponderance of the evidence standard applied in civil suits. *See Noble Drilling Co. v. Drake*, 795 F. 2d 481 (5th Cir. 1986). If the evidence were in equipoise on a particular issue, the true doubt rule enabled a claimant to prevail on that issue. In *Greenwich Collieries*, the Supreme Court held that an injured worker seeking compensation under the Act must prove the elements of his claim by a preponderance of the evidence.[4] As Brady Marine has rebutted the presumption of industrial causation, Mr. Almanzar now bears the burden of proving causation by a preponderance of the evidence. Thus, if in weighing all of the evidence, I find it to be evenly balanced as to the issue of causation, Mr. Almanzar will not prevail.

Dr. Eisenstein examined Mr. Almanzar on three occasions; whereas, Dr. Friedman examined Mr. Almanzar on one occasion. Two of Dr. Eisenstein's examinations are documented in written reports which have been submitted into evidence. The physician diagnosed chronic obstructive

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[4]I note the Benefits Review Board held in *Holmes v. Universal Maritime Servs. Corp.*, 29 BRBS 18, 21 (1995), that "the Supreme Court's decision in *Greenwich Collieries* did not discuss or affect the law regarding the invocation and rebuttal of the Section 20(a) presumption."

pulmonary disease based on the decreased FEV1 values noted on August 11, 1994 and April 11, 2000 pulmonary function studies, a finding of scattered areas of expiratory wheezing on physical examination, and August 11, 1994 and April 11, 2000 chest x-rays which the physician interpreted as showing increased bronchovascular markings. (CX 18, 24). Dr. Friedman diagnosed Mr. Almanzar with a mild to moderate restrictive impairment after examining the Claimant on January 20, 2000. (EX 6). Dr. Friedman found no evidence of obstructive lung disease. In diagnosing a restrictive impairment, Dr. Friedman relied upon the absence of any wheezes, rales, or prolonged expiratory phases on physical examination, a pulse oximetry test, a pulmonary function study and a chest x-ray. (EX 6, 16).

There are several reasons why I find Dr. Eisenstein's opinion insufficient to establish that Mr. Almanzar suffers from a pulmonary condition arising out of and in the course of his employment at Brady Marine. First, Dr. Friedman, a physician who is also board-certified in internal medicine, has attacked each of the bases for Dr. Eisenstein's diagnosis of chronic obstructive pulmonary disease in a well-reasoned and well-documented manner. Dr. Eisenstein stated the April 11, 2000 and August 11, 1994 pulmonary function studies supported a diagnosis of an obstructive impairment because the FEV1 values for both studies were less than 80% of the predicted. (CX 24, p. 14). The study Dr. Eisenstein conducted during the August 11, 1994 examination yielded an FEV1 of 75% of predicted, an FVC value of 65% of predicted and an FEV1/FVC ratio of 94.39. (CX 18). The pulmonary function study test administered on April 11, 2000 yielded an FEV1 of 73% of predicted, an FVC of 70% of predicted, and an FEV1/FVC ratio of 84.6. Dr. Eisenstein considered any FEV1 value below 80% of predicted to be abnormal and diagnostic of an obstruction. (CX 24, p. 14). Dr. Friedman disagreed with Dr. Eisenstein's assertion that the FEV1 value indicates whether someone suffers from an obstructive pulmonary condition. (EX 16, p. 17). The physician stated if an individual has a total reduction in forced vital capacity, which Dr. Friedman acknowledged the Claimant had, the individual's FEV1 will also be reduced. Dr. Friedman stated the FEV1 value is simply a function of the Claimant's total lung capacity. Dr. Friedman testified the FEV1/FVC ratio and the FEF25/75 values are the most "sensitive" indicators of an obstructive impairment. (EX 16, p. 16). The physician testified the FEF 25/75 value on the 1994 study was 103% of predicted and stated than an individual who suffers from an obstructive condition "would never have anything close to that." However, Dr. Friedman did not comment on the FEF 25/75 values for the pulmonary function study he administered on January 20, 2000 or the study conducted during Dr. Eisenstein's April 11, 2000 examination. The studies yielded FEF 25/75 values of 73% of predicted and 83% of predicted respectively, which are significantly lower than the 103%[5] value Dr. Friedman indicated was normal. Nevertheless, Dr. Friedman also stated the FEV1/FVC ratio is another indicator of pulmonary obstruction. Specifically, the physician stated if an individual has obstructive lung disease, the individual's ratio would be less than 75%. Mr. Almanzar's FEV1/FVC ratio was 84.6% on the April 11, 2000 study, 87% on the January 20, 2000 study, and 94.39% on the August 11, 1994 study. (CX 18)(EX 6). Dr. Friedman also disagreed with Dr.

[5] I note the correct FEF value for the 1994 study was 102% of the predicted normal value rather than 103%. (CX 18).

Eisenstein that a finding of increased bronchovascular markings on chest x-rays are supportive of a diagnosis of chronic obstructive pulmonary disease. (EX 16, p. 18). The physician characterized such a finding as "very nonspecific" and stated chronic obstructive pulmonary disease must be diagnosed by pulmonary function tests, unless the patient suffers from advanced emphysema, which would be obvious on a chest x-ray, according to Dr. Friedman. Dr. Friedman interpreted a January 20, 2000 chest x-ray as showing no evidence of interstitial fibrosis. Dr. Eisenstein noted the presence of scattered areas of expiratory wheezing during his August 1994 and April 2000 examinations of the Claimant. However, Dr. Friedman found no rales, wheezes, or prolonged expiratory phases during the April 11, 2000 examination.

Second, I accord greater weight to Dr. Friedman's opinion as to the absence of an obstructive impairment and the presence of a restrictive impairment because Dr. Friedman thoroughly explained how the pulmonary function study evidence supported his conclusion. Dr. Eisenstein simply stated the FEV1 value indicates whether an individual suffers from a pulmonary obstruction and never explained how the other values such as the FVC, the FEF, and the FEV1/FVC ratio supported his diagnosis. Moreover, Dr. Friedman also supported his diagnosis with a pulse oximetry test which he stated was not indicative of an obstructive impairment.

Because Dr. Friedman's opinions cast serious doubt on the validity of Dr. Eisenstein's diagnosis of an occupational pulmonary condition and because Mr. Almanzar bears the burden of proving the existence of an injury arising out of and in the course of his employment, I find Dr. Eisenstein's opinion insufficient to establish the existence of such an injury by a preponderance of the evidence. Consequently, I find Mr. Almanzar has failed to establish by a preponderance of the evidence that he suffers from chronic obstructive pulmonary disease arising out of and in the course of his employment with Brady Marine.

Nature and Extent of Disability

As discussed above, Mr. Almanzar received temporary total disability benefits from the Employer from May 15, 1991 through April 26, 1996 for injuries arising out of the May 14, 1991 accident at the Employer's Trumbull Street Facility. The Claimant is now seeking either permanent total disability benefits or permanent partial disability benefits based on those injuries.

Disability is defined under the Act as an "incapacity to earn the wages which the employee was receiving at the time of the injury in the same or any other employment." 33 U.S.C. §902(10). Therefore, for the Claimant to receive a disability award, an economic loss coupled with a physical and/or psychological impairment must be shown. *See Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Thus, disability requires a causal connection between a worker's physical injury and his or her inability to work. Disability is usually addressed in terms of its nature (permanent or temporary) and its extent (total or partial).

The extent of disability is an economic concept. *See New Orleans (Gulfwide) Stevedores v. Turner*, 661 F. 2d 1031, 1038 (5th Cir. 1981); *Quick v. Martin*, 397 F. 2d 644, 648 (D.C. Cir. 1968). Thus, in order for a claimant to receive an award of compensation, the evidence must establish that the injury resulted in a loss of wage earning capacity. *See Fleetwood v. Newport News Shipbuilding and Dry Dock Co.*, 776 F. 2d 1225, 1229 (4th Cir. 1985); *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1985).

The traditional method for determining whether an injury is permanent or temporary is the date of maximum medical improvement. *See Turney v. Bethlehem Steel Corp.*, 17 BRBS 56, 60 (1985); *Stevens v. Lockheed Shipbuilding Co.*, 22 BRBS 155, 157 (1989). The date of maximum medical improvement is a question of fact based upon the medical evidence of record and, unlike the extent of a claimant's disability, is not based on economic factors. *See Louisiana Ins. Guaranty Assoc. v. Abbott*, 40 F. 3d 122 (5th Cir. 1994); *Ballesteros v. Willamette Western Corp.*, 20 BRBS 184, 186 (1988); *Williams v. General Dynamics Corp.*, 10 BRBS 915 (1979). Mr. Almanzar has the burden of proving the nature and extent of his alleged disability. *See Trask v. Lockheed Shipbuilding Constr. Co.*, 17 BRBS 56, 59 (1980 or 85). The claimant has the burden of proving the nature and extent of his disability without the benefit of the Section 20(a) presumption. *See Carroll v. Hanover Bridge Marina*, 17 BRBS 176 (1985).

To establish a prima facie case of total disability, the Claimant must show that he is unable to return to his regular or usual employment due to his work-related injuries. *See Elliott v. C & P Telephone Co.*, 16 BRBS 89 (1984); *Harrison v. Todd Pacific Shipyards Corp.*, 21 BRBS 339 (1988). A claimant's credible testimony alone, without objective medical evidence, on the existence of a disability may constitute a sufficient basis for an award of compensation. *See Ruiz v. Universal Maritime Serv. Corp.*, 8 BRBS 451, 454 (1978); *Eller & Co. v. Golden*, 620 F. 2d 71, 12 BRBS 348 (5th Cir. 1980). Once a claimant establishes a prima facie case of total disability, the burden shifts to the employer to establish the availability of suitable alternate employment. *See Caudill v. Sea Tac Alaska Shipbuilding v. Director, OWCP*, 8 F. 3d 29 (th Cir. 1993). The employer can establish the availability of suitable alternate employment by showing the existence of realistic job opportunities that the claimant is capable of performing, consider-ing his or her age, education, work experience, and physical restrictions. *See New Orleans (Gulfwide) Stevedores v. Turner*, 661 F. 2d 1031 (5th Cir. 1981). However, the claimant can rebut the employer's showing of the availability of suitable alternate employment by showing he or she diligently pursued alternate employment opportunities but was unable to secure a position. *See Newport News Shipbuilding & Dry Dock Co. v. Tann*, 841 F. 2d 540 (4th Cir. 1988); *Roger's Terminal & Shipping Corp. v. Director, OWCP*, 784 F. 2d 687 (5th Cir. 1986). *cert. denied*, 479 U.S. 826 (1986). If the employer satisfies its burden and the claimant is unable to rebut the presumption as to the availability of suitable alternate employment, the claimant, at most, may be partially disabled.

Mr. Almanzar argues he is permanently and totally disabled from returning to his job as a welder because of the May 14, 1991 accident and injuries sustained therein. (Claimant's Brief, at 24). Therefore, I shall first address whether Mr. Almanzar has established a *prima facie* of total disability.

Vision Loss

Mr. Almanzar sustained an injury to his eye during the May 14, 1991 accident. Dr. J. Calderone diagnosed the Claimant with an eyelid laceration, a periorbital contusion, and a secondary dry eye during the Claimant's hospitalization immediately following the accident. (CX 2). At that time, Dr. Calderone expected Mr. Almanzar's vision to be restored when the Claimant's eyelid swelling resolved and the eyelid returned to its normal function. Dr. Lepore evaluated Mr. Almanzar's vision almost two months after the accident. (CX 5). Dr. Lepore found the Claimant's visual function to be markedly impaired in both eyes. The physician attributed Mr. Almanzar's visual impairment to bilateral diabetic retinopathy, refractive error, and possible bilateral traumatic optic neuropathy. The physician also concluded gun barrel or tubular vision field and sensory loss on the left side of the face complicated Mr. Almanzar's condition. In Dr. Lepore's opinion, it would have been "extremely problematic to unequivocally demonstrate a traumatic optic neuropathy in a patient with retinal disease and functional visual symptoms." Dr. Lepore also found it extremely difficult to give a visual prognosis for the Claimant because the Claimant suffers from two to three visual problems and has a background of post-concussion syndrome.

The physician evaluated Mr. Almanzar's visual status again on March 19, 1993. (CX 5). At that time, Mr. Almanzar was complaining of severe left orbital and head pain. Dr. Lepore again diagnosed diabetic retinopathy, a refractive error and functional visual sensory loss, with no mention of the possible traumatic optic neuropathy. Dr. Lepore commented that the Claimant's left facial sensory loss and gun barrel configuration visual fields do not suggest true organic dysfunction of the central nervous system. The physician also noted Mr. Almanzar suffered from a status post head trauma. Dr. Lepore stated Mr. Almanzar's vision was not as good as it was in 1991. The physician opined the restrictive nature of the Claimant's visual function made returning to work or resuming driving medically inadvisable.

On May 14, 1993, Dr. Panariello, a board-certified opthalmologist, evaluated Mr. Almanzar for complaints of headaches and blurred vision. The physician stated the Claimant's visual acuity without glasses was 20/70 in the right eye and 20/400 in the left eye. Dr. Panariello corrected the Claimant's vision to 20/25 in the right eye and 20/70 in the left eye with refraction. The physician diagnosed Mr. Almanzar with post-concussive syndrome and non-proliferative diabetic retinopathy. Dr. Panariello opined the "main cause" of the Claimant's vision loss is diabetic retinopathy. Although the opinions of Drs. Panariello and Lepore indicate Mr. Almanzar suffers from a severely limited vision, neither of the physicians opinions unequivocally relate Claimant's vision problems to the May 14, 1991accident. However, both Drs. Lepore and Panariello clearly attributed Mr. Almanzar's vision loss

to diabetic retinopathy, a condition unrelated to the May 14, 1991 accident at the Trumbull Street Facility.

Orthopedic Injuries

The evidence of record establishes that Mr. Almanzar suffered from a fractured left mandible and cervical, lumbosacral and right shoulder sprains or strains as a result of the May 14, 1991 accident. The Claimant was hospitalized at Elizabeth General Medical Center from May 14, 1991 to May 21, 1991 due to the injuries he sustained in the accident. (CX 2). An x-ray administered at Elizabeth General Medical Center on May 14, 1991 revealed a left mandibular angle fracture. Dr. Frederick Meiselman, a board certified oral and maxillofacial surgeon, repaired Mr. Almanzar's fractured jaw on May 17, 1991. Dr. Meiselman rendered follow-up treatment to the Claimant until August 16, 1991, when he discharged the Claimant from active treatment with a radiographically healing mandible. (CX 3). Dr. Meiselman saw Mr. Almanzar on three subsequent occasions during 1992 and 1993. The physician removed the Claimant's mandibular bone plate on April 6, 1993 because it was interfering with the Claimant's ability to wear his lower dentures. Dr. Meiselman noted no other problems with Mr. Almanzar's mandibular function and did not render treatment to Mr. Almanzar after 1993.

Several physicians of record have opined Mr. Almanzar suffered injury to his back and right shoulder as a result of the accident at the Trumbull Street Facility. Immediately following the accident, Dr. M. Bercik diagnosed the Claimant with cervical, lumbosacral, and right shoulder sprains. (CX 2). On June 11, 1991, Dr. Andrew Hutter, an orthopedic surgeon, diagnosed Mr. Almanzar with a right shoulder contusion and cervical, lumbar and capsular strains. (CX 7). The physician expected that Mr. Almanzar would have reached his maximum orthopedic benefit during September 1991. The record does not indicate Mr. Almanzar's orthopedic condition was evaluated from August 27, 1991 to November 6, 1995.

The Employer terminated Mr. Almanzar's temporary total disability benefits, at least in part, on the reliance of the opinions of Dr. Armando Martinez as to Mr. Almanzar's orthopedic conditions. (Employer's Brief, at 15). Dr. Martinez examined the Claimant on November 6, 1995 and concluded the Claimant had reached the maximum medical benefit of orthopedic care. (EX 1). Dr. Martinez opined further orthopedic care was not necessary and stated Mr. Almanzar suffers from a 2.5% permanent orthopedic disability. Dr. Martinez stated that if the history reported by Mr. Almanzar was factual, his injuries "could very well be related to" the May 14, 1991 accident. The physician opined Mr. Almanzar is capable of working as a welder from an orthopedic standpoint.

On August 6, 1996, several months after Mr. Almanzar's temporary total disability benefits ceased, Dr. Mitchell Steinway evaluated Mr. Almanzar's orthopedic condition. (CX 14). Dr.

Steinway is a board-certified orthopedic surgeon. The physician diagnosed residual post-traumatic cervical and lumbar sprains, probable cervical and lumbar osteoarthritis, and a right shoulder rotator cuff tear. Dr. Steinway concluded the Claimant's orthopedic dysfunction, coupled with his history of hypertension, his insulin-dependent diabetes mellitus, his pulmonary and psychiatric dysfunction, and residual discomfort in the mandible, Mr. Almanzar is totally and permanently disabled from returning to his usual work as a welder/longshoreman. During a January 4, 2000 examination, Dr. Steinway offered the same diagnoses and conclusions as to the extent of the Claimant's disability. Dr. Steinway stated he expects "no material improvement" in Mr. Almanzar's orthopedic condition in the future and attributed the Claimant's condition to the May 14, 1991 accident. During his October 24, 2000 deposition, Dr. Steinway explained how he arrived at the diagnoses of probable cervical and lumbar osteoarthritis and a right shoulder rotator cuff tear. (CX 22).

Dr. Steven Nehmer examined Mr. Almanzar on May 25, 2000. (EX 2). Dr. Nehmer is also board-certified in orthopedic surgery. Although the Claimant complained of back, neck, and right shoulder pain, Dr. Nehmer concluded the Claimant was engaging in symptom magnification. Dr. Nehmer thought Mr. Almanzar exhibited more subjective complaints than objective findings. The physician acknowledged Mr. Almanzar sustained cervical, lumbar and right shoulder strains in the May 14, 1991 accident; however Dr. Nehmer opined Mr. Almanzar had fully recovered from those injuries and required no further testing or treatment. Dr. Nehmer further opined Mr. Almanzar can perform the job of a welder from an orthopedic standpoint.
Dr. Nehmer also defended his conclusions in a pre-hearing deposition conducted on December 1, 2000. (EX 14).

As discussed above, all of the physicians agree Mr Almnazar suffered from cervical, lumbar and right shoulder injuries as a result of the May 14, 1991 accident; however the physicians disagree as the nature and extent of any disability which may have resulted from those injuries. Neither Dr. Bercik nor Dr. Hutter commented on the level of orthopedic disability from which the Claimant suffers nor did the physicians unequivocally comment on the nature of any orthopedic disability.

Drs. Martinez, Nehmer, and Steinway are the only physicians of record who have rendered opinions as to the nature and extent of the Claimant's orthopedic disability. Dr. Martinez opined Mr. Almanzar reached maximum medical improvement on November 6, 1995 and suffers from a permanent 2.5% orthopedic disability. Dr. Steinway, a board-certified orthopedic surgeon who examined Mr. Almanzar on three occasions from 1996-2000, opined
Mr. Almanzar's orthopedic dysfunction coupled with the Claimant's history of hypertension, insulin-dependent diabetes mellitus, pulmonary and psychiatric dysfunction, and residual discomfort in the mandible, render Mr. Almanzar totally disabled from returning to his usual work as a welder/longshoreman. On January 4, 2000, Dr. Steinway stated he expects no material improvement in Mr. Almanzar's orthopedic condition in the future and again attributed the Claimant's condition to the May 14, 1991accident. The orthopedic dysfunction to which Dr. Steinway referred included his diagnoses of residual post-traumatic cervical and lumbar sprains, probable cervical and lumbar

osteoarthritis, and a torn right rotator cuff. During his deposition, Dr. Steinway testified Mr. Almanzar is totally disabled from an orthopedic standpoint.

Dr. Nehmer, a board-certified orthopedic surgeon, who examined Mr. Almanzar once on May 25, 2000, acknowledged Mr. Almanzar sustained cervical, lumbar, and right shoulder strains in the May 14, 1991 accident, but concluded Mr. Almanzar has fully recovered from those injuries and requires no further orthopedic testing or treatment. Dr. Nehmer opined Mr. Almanzar is capable of performing the job of a welder from an orthopedic standpoint. The physician disagreed with Dr. Steinway's diagnosis of a torn right rotator cuff and rendered no opinion as to whether or not Mr. Almanzar suffered from osteoarthritis of the lumbar and cervical spine.

Although Dr. Steinway and Dr. Nehmer are both highly-qualified physicians, there are several reasons why I accord greater weight to the opinion of Dr. Steinway than to the opinion of Dr. Nehmer. First, Dr. Steinway had the benefit of examining the Claimant on three occasions during a four-year period whereas Dr. Nehmer evaluated the Claimant only once during 2000. Second, Dr. Steinway rendered his opinions as to the nature and extent of the Claimant's orthopedic status based upon a more accurate picture of the Claimant's total medical condition than did Dr. Nehmer. Dr. Steinway was aware of the Claimant's history of myocardial infarction, hypertension, insulin-dependent diabetes mellitus, diabetic retinopathy, psychiatric dysfunction, and renal failure. In contrast, Dr. Nehmer was only aware of the Claimant's insulin-dependent diabetes mellitus and history of hypertension. The physician did not know Mr. Almanzar suffered from diabetic retinopathy or had a history of myocardial infarction. Furthermore, Dr. Nehmer's deposition testimony confirms that the physician did not have an accurate picture of the Claimant's overall medical condition. Dr. Nehmer testified that Mr. Almanzar had better than average muscle tone for someone his age, was an active person, and appeared to exercise regularly, at a time when the Claimant had been advised to no longer drive due to his vision loss, was receiving kidney dialysis three times per week, and was suffering from heart problems. Given the multiple medical conditions from which the Claimant suffers, I seriously question the reliability of Dr. Nehmer's assessment of Mr. Almanzar's physical appearance, muscle tone, and activity level.

Moreover, Dr. Nehmer did not document or explain the examination findings in support of his conclusions as thoroughly as did Dr. Steinway. Although Dr. Steinway is the only physician of record who diagnosed Mr. Almanzar with a torn right rotator cuff, he offered ample clinical findings to support his diagnoses.[6] For example, Dr. Steinway, unlike Dr. Nehmer, recorded the specific values on the

[6]Dr. Steinway supported his diagnoses with clinical findings of stiffness in the Claimant's neck, tenderness and spasm in the trapezius muscles between the shoulders and the neck, atrophy on the right side of the deltoid and supraspinatus muscles, 50% loss of motion in the Claimant's right shoulder, localized tenderness and complaints of pain on palpation in the area where the rotator cuff inserts into the humerus, crepitus or grinding sensations heard on passive shoulder motion, decreased curvature in the lumbar spine, 50% loss of normal lumbar function, sluggish

range of motion tests he conducted on the Claimant's back, neck and right shoulder and explained why the range of motion tests and the clinical examination findings supported his diagnosis of a torn right rotator cuff. Dr. Nehmer stated the range of motion tests he performed on the Claimant's right shoulder showed limited rotations, but did not record specific values identifying the extent of the limitation. (P. 22-23). Dr. Nehmer also criticized Dr. Steinway's diagnosis of a torn right rotator cuff because the physician stated a rotator cuff tear cannot be diagnosed without the benefit of an MRI or some other diagnostic test. However, Dr. Nehmer did not perform such a diagnostic test in ruling out the presence of a rotator cuff tear.

Dr. Nehmer's explanation of the Claimant's subjective complaints of pain and limited back, neck and right shoulder movement was that Mr. Almanzar was engaging in symptom magnification. In his May 2000 examination report, Dr. Nehmer stated he thought Mr. Almanzar was engaging in symptom magnification because he thought the Claimant had "far more subjective complaints than objective findings." The physician also stated "it did not seem as though [Mr. Almanzar] was making a true effort to move his neck, back or shoulder." During his December 4, 2000 deposition, Dr. Nehmer testified as to specific examination findings he made during his examination of the Claimant which led the physician to believe the Claimant was engaging in symptom magnification. However, Dr. Nehmer failed to note those findings in his May 25, 2000 examination report and testified that he had no independent recollection of his examination of the Claimant. Thus, I accord little weight to Dr. Nehmer's deposition testimony discussing specific examination findings not noted in Dr. Nehmer's report because the physician himself testified he had no independent recollection of his examination of the Claimant.

Dr. Steinway testified that he considered the range of motion tests he performed on Mr. Almanzar to be accurate because the tests did not indicate the Claimant was restricting his ability to move his spine or shoulder in any position. I accord greater weight to Dr. Steinway's assessment of the level of effort exhibited by the Claimant on the range of motion tests because Dr. Steinway had several opportunities to evaluate Mr. Almanzar's efforts over a four-year period and thus was in a better position to more accurately determine whether the Claimant was making genuine efforts on the range of motion testing.

Dr. Steinway also opined the neck, back, and right shoulder injuries Mr. Almanzar sustained during the May 14, 1991 accident "aggravated and accelerated the Claimant's preexisting osteoarthritis and cervical disc disease, causing it to become symptomatic and interfere with upper and lower extremity orthopedic function and was the sole contributor to the right shoulder injury and resulting dysfunction." Dr. Steinway based his diagnosis of osteoarthritis and cervical disc disease on two x-

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reflexes, x-ray evidence of degenerative changes in the spine, restricted cervical spine motion, passively in multiple planes, a finding of atrophy in the left thigh, an abnormal gait while walking, walking with torso bent forward 20 degrees, a decrease in straight leg raising, and some bursal thickening around the right shoulder. (CX pp. 20 -23).

rays[7] taken after the accident in 1991 as well as findings of restricted cervical spine motion in multiple planes, complaints of persistent neck pain, and straightening of the cervical curvature or cervical lordosis. Dr. Steinway explained that effect of a back sprain can be different in an person who suffers from osteoarthritis of the cervical and lumbar spine. According to Dr. Steinway, osteoarthritis causes stiffness and resulting abnormal functioning of the back and neck. When soft tissue abnormalities to muscles and ligaments are superimposed on the bony abnormalities caused by osteoarthritis, the disability an individual has from a bony injury will be exacerbated and accelerated. I note that when work-related injuries aggravate, exacerbate, accelerate, contribute to, or combine with a previous infirmity, disease, or underlying condition, the entire resultant condition is compensable under the Act. *See Wheatley v. Adler*, 407 F. 2d 307 (D.C. Cir. 1968).

Dr. Nehmer did not address the x-ray evidence of degenerative changes in the spine and did not comment on the presence or absence of osteoarthritis or cervical disc disease even though he indicated that he reviewed the medical records from Elizabeth General Medical Center and Dr. Hutter. Dr. Nehmer testified that the 1991 cervical spine x-ray from Elizabeth General Medical Center was basically normal and thus furthered his diagnosis of cervical strain; however, the physician did not comment on the minimal to moderate degenerative osteoarthritic changes Dr. Whitaker noted in the cervical spine. (CX 2). Likewise, when asked about the mild degenerative changes noted on a June 17, 1991 lumbar spine x-ray administered during Dr. Hutter's examination, Dr. Nehmer testified the x-ray supported his diagnosis of a lumbar strain. However, Dr. Nehmer offered no explanation as to whether the Claimant suffered from degenerative osteoarthritic changes in his spine and offered no opinion as to whether the presence or absence of such a condition supported his diagnoses of cervical and lumbar strains. As to the existence of degenerative osteoarthritic changes in the Claimant's spine, I accord greater weight to the opinion of Dr. Steinway than to the opinion of Dr. Nehmer.

For the above-stated reasons, I find Mr. Almanzar sustained cervical and lumbar sprains due to the May 14, 1991 accident which aggravated and acclerated his preexisting osteoarthritic condition and resulted in a torn right rotator cuff and restricted back, neck, and shoulder movement. On August 6, 1996, Dr. Steinway concluded that Mr. Almanzar's orthopedic conditions coupled with other non-work related conditions have rendered Mr. Almanzar totally disabled from performing his usual job as a welder. On February 10, 1998 and January 4, 2000, the physician stated Mr. Almanzar is totally disabled but did not state whether the orthopedic conditions rendered Mr. Almanzar totally disabled or whether the non-work related conditions contributed to the Claimant's disability. During his October 24, 2000 deposition, Dr. Steinway testified Mr. Almanzar is totally disabled from an orthopedic

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[7]On the day of the accident, Dr. Whitaker of Elizabeth General Medical Center interpreted the Claimant's cervical spine x-ray as showing mild degenerative osteoarthritic changes. (CX 2). Dr. Hutter also interpreted a June 11, 1991 x-ray as showing mild degenerative changes in the lumbar spine without having the benefit of reviewing the x-rays taken during the Claimant's May 1991 hospitalization at Elizabeth General. (CX 7).

standpoint, but offered no explanation for the change in his opinion since 1996. Dr. Martinez diagnosed the Claimant with a partial (2.5%) orthopedic disability on November 6, 1995 and stated the Claimant is capable of working from an orthopedic standpoint. Dr. Nehmer opined Mr. Almanzar is capable, from an orthopedic standpoint, of performing the job of a welder. For the reasons stated above, I accord greater weight to Dr. Steinway's opinion as to the extent of disability than to Dr. Nehmer's opinion.

As for Dr. Steinway's diagnoses of both partial and total orthopedic disability, I accord greater weight to his diagnosis of a partial orthopedic disability because a finding of a partial orthopedic disability is supported by the opinion of Dr. Martinez and because Dr. Steinway offered no explanation for changing his opinion to that of total orthopedic disability. Consequently, I find Mr. Almanzar has not established the orthopedic injuries he sustained in the May 14, 1991 accident have rendered him totally disabled from performing his usual employment as a welder.

I also find the work-related orthopedic injuries Mr. Almanzar sustained are permanent in nature. As mentioned above, there are two tests an administrative law judge can utilize to determine whether a work-related injury is permanent or temporary in nature. I find the date of permanency to be the same under both tests. According to the first test, a residual disability will be considered permanent when the employee's condition reaches maximum medical improvement. *See James v. Pate Stevedoring Co.*, 22 BRBS 271, 274 (1989); *Phillips v. Marine Concrete Structures*, 21 BRBS 233, 235 (1988); *Trask v. Lockheed Shipbuilding & Constr. Co.*, 17 BRBS 56, 60 (1985). Dr. Bercik offered no opinion as to the nature or extent of any orthopedic disability. Dr. Hutter stated he expected Mr. Almanzar to reach maximum orthopedic improvement during September 1991; however, such a statement is too speculative to establish the date of maximum medical improvement. *See Steig v. Lockheed Shipbuilding & Constr. Co.*, 3 BRBS 439, 441 (1976). Dr. Martinez opined Mr. Almanzar had reached maximum medical improvement with respect to his orthopedic injuries on November 6, 1995 and required no further orthopedic treatment. In rendering his opinion as to the nature of the Claimant's disability, Dr. Martinez considered the soft tissue injuries to the Claimant's back, neck, and right shoulder. Dr. Nehmer opined Mr. Almanzar has fully recovered from his cervical, lumbar, and right shoulder strains and thus does not suffer from a permanent orthopedic disability. Dr. Steinway repeatedly has opined Mr. Almanzar's orthopedic disability is permanent in nature. The physician stated that with respect to the right shoulder injury, the date of maximum medical improvement was the first time the physician examined Mr. Almanzar on August 6, 1996, but could have been earlier. As to the date of maximum medical improvement, I accord the greatest weight to the opinion of Dr. Martinez because his opinion contains the earliest reasoned and documented opinion as to the date of maximum medical improvement.

Under the second test used to determine the nature of a claimant's injury, an administrative law judge may also find a claimant's injury to be permanent in nature where the impairment has continued for a lengthy period of time and appears to be of a lasting or indefinite duration. *See Watson v. Gulf Stevedore Corp.*, 400 F. 2d 649, 654 (5th Cir. 1968), *cert. denied*, 394 U.S. 976 (1969). Dr. Martinez opined the Claimant's orthopedic disability was permanent in nature as early as November 6, 1995. Dr. Steinway characterized Mr. Almanzar's orthopedic disability as permanent in nature from

the first time he examined the Claimant on August 6, 1996 through the last time he examined Mr. Almanzar on January 4, 2000. On January 4, 2000, Dr. Steinway also stated he expects no material improvement in Mr. Almanzar's orthopedic condition in the future. Such a prognosis is sufficient to support a finding that any orthopedic disability from which the Claimant suffers is permanent in nature. *See Walsh v. Vappi Constr. Co.*, 13 BRBS 442, 445 (1981); *Johnson v. Treyja, Inc.*, 5 BRBS 464, 468 (1977). Again, I accord greater weight to Dr. Martinez's diagnoses of permanency because it is the earliest
reasoned and documented opinion as to the nature of the Claimant's disability and is not contradicted by Dr. Steinway's opinion. As to the nature of the Claimant's disability, I find Dr. Nehmer's opinion is entitled to little evidentiary weight for the reasons stated above. Consequently, I find Mr. Almanzar's orthopedic disability became permanent on November 6, 1995, the date of Dr. Martinez's examination report.

Psychiatric Injuries

Mr. Almanzar also alleges he suffers from permanent psychiatric conditions because of the May 14, 1991 accident which contribute to his inability to return to work as a welder. Since the May 14, 1991 accident, Mr. Almanzar has been treated or evaluated by at least six psychiatrists.

Drs. Castillo, Moreno, and Mendelson rendered psychiatric treatment to Mr. Almanzar on more than one occasion. Dr. Castillo diagnosed Mr. Almanzar with a prolonged depressive disorder on May 29, 1996, but did not relate the condition to the May 14, 1991 accident or any injuries arising therefrom. Dr. Castillo also offered no opinion as to the nature and extent of the Claimant's disability. (CX 12). Dr. Mendelson, a board-certified psychiatrist and neurologist, treated Mr. Almanzar on a number of occasions from September 1991 through February 1992. (Cite). In September 1991, Dr. Mendelson stated the Claimant's history and examination suggested a post-traumatic headache syndrome; however the physician was unable to find any organic basis for the Claimant's complaints of headaches, left facial numbness, and vision loss. Dr. Mendelson also thought Mr. Almanzar's headaches could be the result of anxiety about returning to work or depression. Dr. Mendelson treated Mr. Almanzar until December 16, 1992, when Dr. Mendelson concluded Mr. Almanzar had reached maximum medical improvement. At that time, Dr. Mendelson found no reason why the Claimant could not return to work. Dr. Moreno treated Mr. Almanzar's psychiatric condition from March 1992 through November 1993. (CX 8)(EX 3). On March 13, 1992, Dr. Moreno diagnosed Mr. Almanzar with an adjustment disorder with mixed emotional features and stated amnestic syndrome and organic mood syndrome needed to be ruled out as possible diagnoses. The physician attributed the Claimant's mental status to anxiety and depression which Dr. Moreno thought appeared to be triggered by the difficulties Mr. Almanzar had experienced since the May 14, 1991 accident. During the course of his treatment of the Claimant, Dr. Moreno noted improvement in the Claimant's mood, headaches, and symptoms. Less than two months after Dr. Moreno noted such an improvement, the Claimant began to complain of a regression in his symptoms and was concerned about Dr. Moreno possibly wanting him to return to work. At that point, Dr. Moreno became

concerned that secondary gain may be an issue with Mr. Almanzar. By January 1993, Dr. Moreno concluded Mr. Almanzar was making conscious attempts to aggravate his symptoms. Dr. Moreno found the Claimant's complaints to be contradictory to his observations of the Claimant. Dr. Moreno concluded Mr. Almanzar reached maximum medical improvement on November 1, 1993 and that consideration should have been given to reintegrating the Claimant into the work force.

Dr. Richard Fillippone, a clinical neuropsychologist, evaluated Mr. Almanzar's condition on August 8, 1993. (EX 8). Dr. Fillipone concluded Mr. Almanzar was "faking" his psychiatric problems and cognitive deficits and was motivated by secondary gain. The physician stated he was unable to properly evaluate the Claimant's true cognitive abilities because the Claimant was not motivated to give accurate responses. Dr. Fillipone found Mr. Almanzar's performance during the evaluation to be inconsistent with a head injury because of the severity of some of the Claimant's cognitive results, the inconsistency on others, and a complete lack of correlation between the Claimant's cognitive skills and his capacity to perform daily living activities. Dr. Fillippone acknowledged Mr. Almanzar may have suffered headaches following the May 14, 1991 accident; however, the physician stated the Claimant's malingering prevented him from determining the degree to which the Claimant may still suffer headaches.

Dr. Ferretti, a board-certified neurologist and psychiatrist, evaluated Mr. Almanzar's psychiatric condition on several occasions, but never rendered psychiatric treatment to the Claimant. When Dr. Ferretti initially examined the Claimant on May 17, 1993, he diagnosed an adjustment reaction of adult life with features of anxiety, depression, and phobia, possible neuropsychological dysfunction, and post-traumatic headaches in partial remission. The physician stated there appeared to be no psychiatric permanency and that the issue of secondary gain needed to be addressed. After an April 22, 1996 examination, Dr. Ferretti reiterated his diagnoses of an adjustment reaction of adult life with features of anxiety, depression and phobia and post-concussion headaches. The physician also stated neuropsychological dysfunction secondary to a closed head injury with loss of consciousness needed to be ruled out as a possible diagnosis. The physician thought it would be unreasonable for the Claimant to return to work as a welder given his subjective complaints. Dr. Ferretti stated the evidence indicated Mr. Almanzar is categorically disabled. During an October 17, 2000 examination, Dr. Ferretti found Mr. Almanzar's condition to be significantly worse. I note the evidence of record indicates Mr. Almanzar's non-work related conditions began to worsen during 1998 when the Claimant went into renal failure and began receiving dialysis three times each week. On October 17, 2000, Dr. Ferretti diagnosed the Claimant with chronic depression, anxiety, sleep disturbance, phobia, a neuropsychological dysfunction secondary to a closed head injury with loss of consciousness, and post-concussion headaches with dizziness. The physician stated Mr. Almanzar is totally and permanently disabled for all work due to the deterioration in his physical condition caused by non-work related conditions such as diabetes mellitus, renal disease, coronary artery disease, and hypertension. Dr. Ferretti stated the Claimant's work-related injuries are a substantial cause of his depression . Dr. Ferretti concluded the May 14, 1991 accident is a substantial contributing cause of the Claimant's disability and inability to work. Dr. Ferretti also stated the Claimant's renal illness plays a substantial

role in his psychiatric disability. Dr. Ferretti rated the Claimant's global assessment of functioning at 40, a rating Dr. Ferretti considered very low.

Dr. Head, a board-certified psychiatrist, diagnosed Mr. Almanzar as a malingerer after examining the Claimant once on July 13, 2000. (EX 5). Dr. Head diagnosed Mr. Almanzar as a malingerer and stated the Claimant was attempting to simulate psychopathology for purposes of his claim. The physician opined the Claimant's non-work related conditions prevent the Claimant from working. Dr. Head also diagnosed Mr. Almanzar with a phase of life problem. Dr. Head opined Mr. Almanzar sustained no permanent psychiatric condition or disability related to the May 14, 1991 accident. The physician stated whatever transient emotional complaints the Claimant may have initially suffered as a result of the May 14, 1991 accident have objectively resolved, without permanent psychiatric residuals." Dr. Head acknowledged the Claimant's original psychiatric complaints were likely due to the May 14, 1991 accident. Dr. Head found no reason to impose psychiatric restrictions on Mr. Almanzar's ability to work and thought vocational guidance was not necessary. The physician opined the Claimant will not experience any future worsening of his psychiatric condition. Dr. Head rated the Claimant's global assessment of function as 70, a rating which Dr. Head considered to be normal.

As discussed above, Drs. Moreno, Mendelson, Fillippone, and Head are of the opinion that Mr. Almanzar does not suffer from a disabling psychiatric condition. As early as December 16, 1992, Dr. Mendelson, the Claimant's treating psychiatrist, found no organic basis for the Claimant's psychiatric complaints and found no reason why Mr. Almanzar could not return to work. During January 1993, the Claimant's other treating psychiatrist, Dr. Moreno thought the Claimant was trying to aggravate his symptoms and that secondary gain may be an issue with the Claimant. Likewise, Dr. Fillipone an examining physician of record, has concluded that secondary gain motivated Mr. Almanzar to fake his psychiatric problems and cognitive deficits. Dr. Head, another examining physician of record, opined Mr. Almanzar suffers from no permanent psychiatric condition or disability because of the May 14, 1991 accident.

Dr. Ferretti is the only physician of record who has opined Mr. Almanzar suffers from a permanent psychiatric disability caused by the injuries he sustained in the May 14, 1991 accident. However, when Dr. Ferretti initially diagnosed Mr. Almanzar on May 17, 1993, he stated there appeared to be no psychiatric permanency and thought the issue of secondary gain needed to be addressed. During his April 22, 1996 evaluation, Dr. Ferretti stated the evidence appeared to indicate the Claimant is categorically disabled. The physician did not mention his prior finding of no psychiatric permanency or his prior concern about secondary gain. By October 17, 2000, Dr. Ferretti diagnosed chronic depression among other conditions and stated Mr. Almanzar was totally and permanently disabled due to his non-work-related conditions and work-related conditions. The physician attributed the Claimant's depression to his work-related injuries and stated renal illness plays a role in the Claimant's psychiatric disability.

Based on my review of the evidence of record, I find Mr. Almanzar has established that he continues to suffer from depression caused by the injuries he sustained on May 14, 1991. Moreover, I find the evidence establishes that the chronic depression from which the Claimant suffers contributes to the Claimant's psychiatric disability which contributes to the Claimant's inability to work. The diagnosis of depression is supported by the opinions of Drs. Ferretti, Moreno, and Castillo, two of which were the Claimant's treating psychiatrists.

The evidence of record also established that Mr. Almanzar's depression is permanent in nature. Although Dr. Mendelson opined the Claimant reached maximum psychiatric improvement on December 16, 1992, Mr. Almanzar received psychiatric treatment from Dr. Moreno until November 1, 1993. Thereafter, Dr. Castillo and Dr. Ferretti continued to diagnose the Claimant with depression. Dr. Ferretti did initially conclude there was no psychiatric permanency; however, the physician testified the Claimant's psychiatric condition was permanent in nature. Given the marked deterioration in the Claimant's non-work-related conditions in the period between Dr. Ferretti's initial opinion as to no permanency and his final opinion that the Claimant's psychiatric disability is permanent, I find no reason to doubt Dr. Ferretti's change in his opinion as to the nature of the Claimant's depression. Dr. Ferretti last evaluated Mr. Almanzar on October 17, 2000 and concluded the Claimant was permanently disabled due to non-work-related conditions. However, the physician's deposition testimony indicates the Claimant's psychiatric condition is permanent in nature. Therefore, I find Dr. Ferretti's October 17, 2000 report and his deposition testimony indicate Mr. Almanzar's psychiatric condition was permanent as of October 17, 2000. Consequently, I find Mr. Almanzar's psychiatric disability became permanent on October 17, 2000, the date the Claimant was last evaluated by Dr. Ferretti.

Although, as discussed above, I have found that Mr. Almanzar suffers from permanently disabling orthopedic and psychiatric injuries due to the May 14, 1991 accident, the evidence of record is insufficient to establish that these permanent work-related injuries have rendered Mr. Almanzar totally disabled from engaging in the job of a welder. The medical and vocational evidence of record clearly establishes Mr. Almanzar is unable to engage in any type of gainful employment. However, the Claimant's non-work related conditions such as insulin-dependent diabetes mellitus, diabetic retinopathy, and the Claimant's heart and kidney problems, also play a substantial role in the Claimant's inability to work. Therefore, I find Mr. Almanzar has established that his permanent work-related injuries are only partially disabling. Consequently, Mr. Almanzar has failed to establish a prima facie case of total disability under the Act. Nevertheless, the Claimant shall be compensated in accordance with the Act for his permanent partial disability.

Compensation

The Claimant's permanent work-related shoulder and back injuries and depression are not scheduled injuries under the Act; therefore, they shall be compensated under section 8(c)(21). *See Grimes v. Exxon Co. U.S.A.*, 14 BRBS 573, 576 (1981); *McDevit v. George Hyman Construction Co.*, 14 BRBS 677, 680 (1982). Section 8(c)(21) provides that permanent partial

disability compensation for unscheduled injuries shall be 66 and 2/3 percent of the difference between the Claimant's average weekly wage at the time of the injury and his wage earning capacity thereafter in the same or other employment. The parties have stipulated the Claimant's average weekly wage at the time of the May 14, 1991 accident was $697.47. The only vocational evidence of record is a report prepared by Charles Kincaid. Mr. Kincaid concluded the Claimant's wage earning capacity has been eliminated due to his back, neck, shoulder, vision, and stamina problems, his continuing medical involvement, his educational level, and work history. Accordingly, I find Mr. Almanzar's wage earning capacity is $0. Therefore, Mr. Almanzar's loss of wage earning capacity is equal to his average weekly wage at the time of the accident. Thus, Mr. Almanzar is entitled to $464.93 per week for the duration of his permanent partial disability.

Section 8(f) Relief

Section 8(f) transfers an employer's liability to a special fund after the employer pays the first 104 weeks of disability compensation. In order for an employer to receive relief under Section 8(f), the courts have required that three criteria be satisfied. First, the employee must have had a preexisting permanent partial disability. Second, the preexisting condition must have been manifest to the employer. Third, the preexisting partial disability must have contributed to the seriousness of the work-related injury. *See Jacksonville Shipyards, Inc. v. Director, OWCP*, 851 F. 2d 1314, 1316 (11th Cir. 1988); *C & P Telephone, Co. v. Director, OWCP*, 564 F. 2d 503, 514 (D.C. Cir. 1977). Although the evidence relating to the application of Section 8(f) "is to be construed liberally in favor of the employer," the employer has the burden of proof to establish entitlement to relief. *See Director, OWCP v. Newport News Shipbuilding & Dry Dock Co.*, 737 F. 2d 1295, 1298 (4th Cir. 1984). Because Brady Marine has not established that Mr. Almanzar suffered from a pre-existing permanent partial orthopedic or psychiatric disability prior to the May 14, 1991 accident, I find Brady Marine is not entitled to Section 8(f) relief.

Attorney's Fee

Claimant's counsel is allowed thirty days from the service date of this decision to file his attorney fee application, if appropriate. The application shall be prepared in strict accordance with 20 C.F.R. § 725.365 and 725.366. The application must be served on all parties, including the Claimant, and proof of service must be filed with the application. The parties are allowed thirty days following service of the application to file objections to the application for an attorney's fee.

ORDER

Based on the above findings of fact and conclusions of law, it is hereby ORDERED that Juan Almanzar is entitled to the compensation listed below as a result of the claim involved in this proceeding. The specific computations of the award and interest shall be administratively performed by the district director.

1. Employer/Administrator shall pay to Juan Almanzar compensation for permanent partial disability at the rate of $464.94 per week beginning November 6, 1995.

2. Employer shall be entitled to a credit for all payments of disability compensation already made to Mr. Almanzar under the Act.

3. Interest shall be paid on all accrued benefits in accordance with the rate applicable under 28 U.S.C. § 1961, computed from the date each payment was originally due, until paid. The appropriate rate shall be determined as of the filing date of this decision with the district director.

4. Employer shall furnish reasonable, appropriate and necessary medical care to Mr. Almanzar as required by Section 7 of the Act.

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JOSEPH E. KANE
Administrative Law Judge